RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 69032

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 526 E. Hayden)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5746

206

2. FULL NAME Jose Montjano

(a) Residence. No. 526 E. Hayden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: mexican
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jan 19-1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER Jose Montjano
11. BIRTHPLACE OF FATHER (city or town) (State or Country) mexico
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Jose Montjano
(Address) Pocatello Idaho

15. Filed 1/31, 1930 J. Franz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to 1-19, 1930
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Traumatic delivery
cord not ligated
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) D C Ray M. D.
1-19, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hoyt Cem Pocatello — Date of Burial: Jan 22 1930
20. Undertaker: Schumacher & Beasley — Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**; and **children, not gainfully** employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S69125

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME Verna Larson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan. 6 - 1930

7. AGE Years Months Days: If LESS than 1 day, stillborn hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Arco, Idaho

PARENTS
10. NAME OF FATHER C. S. Larson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad, Idaho
12. MAIDEN NAME OF MOTHER Mayme Girard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salmon City, Idaho

14. Informant Chas. S. Larson
(Address) Arco, Idaho

15. Filed Jan. 7, 1930 T. Ball Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1930 to Jan 6 1930, that I last saw h alive on , 19 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis

(Signed) J. W. Egbert M. D.

Jan 6, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Arco, Idaho — Date of Burial: Jan. 7 1930

20. Undertaker: Theo R. Garmin — Address: Arco, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

105

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting **from childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 69142

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

(No. 3 mi south)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

162 Hall

2. FULL NAME Baby Potter

(a) Residence. No. 3 mi south St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 4th 30

7. AGE Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa, Idaho

PARENTS

10. NAME OF FATHER J. H. Potter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grand Island Nebraska

12. MAIDEN NAME OF MOTHER Margie Patrick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant W. H. Potter
(Address) Nampa, Idaho

15. Filed 1-6, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__ to ____, 19__

that I last saw h__ alive on no, 19__

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Still Born.
Trauma on cord caused breathing in utero. No heart beat at birth.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Virgin to deliver but baby was dead (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Grace Bethrop, M. D.

1-6, 1930 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 1-6 1930

20. Undertaker: Mrs. Nina M. Talley — Address: Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

OCT 5 1966

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from **childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S 69458

Local Registrar's No. 32

PLACE OF DEATH

County of Bingham

City of Shelley

Registration District No. 121

Primary Registration District No. 2194

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Landon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

Stillborn ~~Feb 27 30~~

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Asgard Ida

PARENTS

10. NAME OF FATHER Charles Landon

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Portage Wis

12. MAIDEN NAME OF MOTHER Gladys Session

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Astor Wis

14. Informant Charles Landon

(Address) Idaho Falls, Idaho R.F.D.

15. Filed Feb. 28, 1930 Mrs Helen E. Atwie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 27 30
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Stillborn, 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above at ..... m.

The CAUSE OF DEATH* was as follows: Was born dead

Not known

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted? If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. W. Roberts, M. D.

Feb. 28, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Goshen, Idaho — Date of Burial Feb 28 1930

20. Undertaker ..... — Address .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** **Women at home,** who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. **Always qualify** as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull,** and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. S 69525

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006 Local Registrar's No. 25
(No. Samaritan Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

306

2. FULL NAME Dale Herring

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 21st 1930

7. AGE: Years | Months | Days | 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER A. R. Herring
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Ester M. Good
13. BIRTHPLACE OF MOTHER (city or town) Ind.
(State or County)

14. Informant A. R. Herring
(Address) Nampa Idaho

15. Filed 3-3, 1930 Bertha Conway
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 21 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to Feb. 21, 1930
that I last saw him alive on Feb. 21, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? None
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) W. C. Wolfe M. D.
Feb 22, 1930 (Address) Nampa, Ida

19. Place of Burial, Cremation, or Removal: Kohlenberger-Nampa | Date of Burial: 2-21 1930
20. Undertaker: Mrs. Nina M. Talley | Address: Nampa Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S 69576

Local Registrar's No. 208

Registration District No.

Primary Registration District No.

PLACE OF DEATH

County of Gem

City of Emmett

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Son Henry Duberke

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb. 18 - 1930

7. AGE: Years: New Born; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS

10. NAME OF FATHER: Henry Duberke

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Laura Meisner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn

14. Informant: Henry Duberke
(Address) Emmett Idaho

15. Filed 2/19, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth, 19..., to 2-18-30, 19...

that I last saw h... alive on 2-18-30, 19...

and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows: Could not get his lungs to open up.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Reynolds, M. D.

2/19, 1930 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho

Date of Burial: 2/19 1930

20. Undertaker: C. D. Buckneum

Address: Emmett Idaho

10B

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 69607

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 35

(No.) 406

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Gust Kutulas

(a) Residence. No. 406 So 13th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Mch 4, 1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, 8 hrs. or 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER Gust Kutulas

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Greece

12. MAIDEN NAME OF MOTHER Mazie Brundage

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ills.

14. Informant Gust Kutulas
(Address) Coeur d'Alene

15. Filed 3/4, 1930 H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19—, to March 4, 1930
that I last saw ~~living~~ ~~alive on~~ March 4, 1930
and that death occurred, on the date stated above, at Birth 10 p.m.

The CAUSE OF DEATH* was as follows:
Premature - Still born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abnormal position of uterus 7 months

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) Harold J. Sturges, M. D.

3-6, 1930 (Address) C d A Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery | Date of Burial: 3/6 1930

20. Undertaker: C B Mooney | Address: Coeur d'Alene

no B

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. **If the information cannot be secured, it should be plainly stated unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FORM V. S. No. 5-25 M. 1-19

MAR 19 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. S 69835
Local Registrar's No. 37

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2-1-0
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn Baby Lackyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6. DATE OF BIRTH: February (Month) 9 (Day) 1930 (Year)

7. AGE: Stillborn Yrs. ..... Mos. ..... ds. .....
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls, Idaho

10. NAME OF Father: William Theodore Lackyer

11. BIRTHPLACE OF FATHER (State or Country): Lesli, Bingham County Ida

12. MAIDEN NAME OF MOTHER: Genevieve Wadsworth

13. BIRTHPLACE OF MOTHER (State or Country): Taylor, Bonneville Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Theodore Lackyer
(Address) Shelley Route #1

15.
Filed Jan 21 1930 [signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-9 1930 to 2-9 1930 that I last saw him alive on Stillborn 1930 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
(Still Born) about 6 months
Mother suffering from stopping of Bowels.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
2-9 1930 (Address) [signature]

*State the Disease Causing Death; or in deaths from Violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cremated
DATE OF BURIAL: Feb 18 1930

20. UNDERTAKER: Jack A. Wood
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 69854

PLACE OF DEATH
County of
City of Swan Falls

Registration District No. 7
Primary Registration District No. 2006
(No. Swan Falls Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

2. FULL NAME Baby Barkers

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.: no

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Swan Falls Idaho

PARENTS

10. NAME OF FATHER Fred Barker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Albion Idaho
12. MAIDEN NAME OF MOTHER Iretta Baugh
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) Wife Swan Falls Idaho

15. Filed 3/27, 1930 Ruth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 3-26, 1930, that Infant was Still Born 19
and that death occurred, on the date stated above, at 3 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. R. Fraser, M. D.
19 (Address)

19. Place of Burial, Cremation, or Removal: Kohlerlawn Nampa. Date of Burial: 3-27 1930
20. Undertaker: Mrs. D. Falley Address: Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

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A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 69855

PLACE OF DEATH

County of .....

City of .....

Registration District No. 7

Primary Registration District No. 2006 Local Registrar's No. 36

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Barker

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26th 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
			no

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls
(State or country) Idaho

PARENTS

10. NAME OF FATHER Ivo Barker

11. BIRTHPLACE OF FATHER (city or town) Albion
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Iretta Baugh

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah

14. Informant Dr W M. Barker
(Address) Twin Falls

15. Filed 3/27, 1930 Ruth Cowell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3-26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 3-26, 1930 that deceased was stillborn alive, 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Premature birth

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary) .....
.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. R. Frazier, M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa, Date of Burial: 3-27 1930

20. Undertaker: W. Dudley, Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. S 76035

Local Registrar's No.

2. FULL NAME Baby Denhert

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 16 1930

7. AGE: Years X Months X Days X IF LESS than 1 day, hrs. or min. Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER R W. Denhert

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Marie Russee

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant R W Denhert

(Address) Buhl

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

11 PM

16. DATE OF DEATH March 16 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

was born dead result of extensive burns of mother

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Scott, M. D.

3-21, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl — Date of Burial: Mar 22 1930

20. Undertaker: F. L. Drake — Address: Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) **Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S70493

PLACE OF DEATH
County of Bonneville
City of Iona

Registration District No.
Primary Registration District No.
Local Registrar's No. 75
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Clouward
(a) Residence. No. Iona, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 13, 1930

7. AGE: Years 0 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iona, Idaho

PARENTS
10. NAME OF FATHER: Fenon Clouward
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iona, Idaho
12. MAIDEN NAME OF MOTHER: Elda Knowles
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan, Utah

14. Informant: Mrs. Lou. Knowles
(Address): Iona, Idaho

15. Filed April 14, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 13, 1930 that I last saw h alive on April 13, 1930 and that death occurred, on the date stated above, at 9-30 a m.

The CAUSE OF DEATH* was as follows:
Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo. A. Huppert M.D. M.D.
, 19 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona, Idaho — Date of Burial: April 14 1930

20. Undertaker: Jack A. Word — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, **as Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed**, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as **"PUERPERAL septicemia," "PUERPERAL peritonitis,"** etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70613 S

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015

Local Registrar's No. 18

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wanda Louise Richardson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Still

7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9. BIRTHPLACE (city or town) Rupert
(State or country) Idaho

PARENTS

10. NAME OF FATHER J. L. Richardson
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Lenora Bond
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Nebraska

14. Informant J. L. Richardson
(Address) Rupert Idaho

15. Filed 6-10, 1930 Elt Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Asphyxia Neonatorum
.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Layne A. Kenney M. D.
5-13, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetery
Date of Burial: Apr 20 1930

20. Undertaker: W. A. Goodman
Address: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153

File No. 13
Registered No. 71007

1. PLACE OF DEATH

County of Gooding

City of Dorlington Ida. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Fullmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1930 (Year)

7. AGE: Still Born Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dorlington Ida.

10. NAME OF FATHER: Albert W. Fullmer

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Norma Richardson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Fullmer
(Address) Roberts Star Route

15. Filed 7/7 1930 R. L. Morrow Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Still Born (Month) ..... (Day) ..... 19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Still Born

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elias Baker M. D.

19..... (Address) Mackay

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dallington Ida. DATE OF BURIAL: June 16 1930

20. UNDERTAKER: Verne Keller ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

no B

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S 71181

Local Registrar's No.

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2086

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dewey Lee Bosford

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): June 23 30

7. AGE: Years — Months — Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stall

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: R C Bosford

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Florence Jarman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: R C Bosford
(Address): Filer

15. Filed July 9th 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 23, 1930
that I last saw him alive on June 23, 1930
and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH* was as follows:

Stillbirth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech presentation

Instrumental (duration) One hour ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Instrumental Delivery

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) F. A. Dwight, M. D.

June 23rd 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer — Date of Burial: June 23 1930

20. Undertaker: F. L. Drake — Address: Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FORM V. S. No. 5 A—25 M. 1-19

RECEIVED AUG 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

S

File No. 71227

Registered No. 58

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

1. PLACE OF DEATH

County of Franklin

City of Franklin

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Egan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: August 3 (Month) (Day) 1930 (Year)

7. AGE: ✓ Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin, Idaho.

10. NAME OF FATHER: William Rawson Egan

11. BIRTHPLACE OF FATHER (State or Country): Richmond, Utah

12. MAIDEN NAME OF MOTHER: Lulu Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): William Rawson Egan

(Address): Franklin Idaho

15.

Filed ..... 19 .....

A. R. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 3 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1930, to Aug. 3 1930 that I last saw her alive on Did not live 1930 and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows: Trauma incident to delivery, Resuscitation Passage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene Worley M. D.

Aug 3 1930 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richmond Utah

DATE OF BURIAL: Aug 3 1930

20. UNDERTAKER: John M Richards

ADDRESS: Logan Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

1203

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. S 71291

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 205

(No. St Lukes)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stanley Gordon Jr.

(a) Residence. No. 1206 No. 13th St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wht

5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Boise
(State or country) Ida

PARENTS

10. NAME OF FATHER Stanley R Gordon

11. BIRTHPLACE OF FATHER (city or town) Weiser
(State or Country) Ida

12. MAIDEN NAME OF MOTHER Evaline G. Stewart

13. BIRTHPLACE OF MOTHER (city or town) Ontario Ore
(State or County)

14. Informant Stanley R. Gordon
(Address) 1206 - No 13th St Boise Ida

15. Filed 7-21, 1930 W. A. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to ....., 19....
that I last saw him alive on July 16, 1930
and that death occurred, on the date stated above, at 6 PM.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature birth
(6½ months foetus)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. B. Beach, M. D.

July 17, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: July 17 1930

20. Undertaker: Schreiber & McCann — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 71397

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No. 347 Overland, Ave.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Dewey (Infant)
(a) Residence. No. 347 Overland St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12-1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Idaho.

PARENTS
10. NAME OF FATHER Edie Dewey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Elizabeth Camp.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Informant Mrs E. L. Dewey
(Address) Burley, Ida.

15. Filed 7-11-, 1930 F. K. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11:15 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Seven months Gestation
Premature Birth
(Death in Utero)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Being in Auto Ride with mom
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. E. Lemon, M. D.
June 16, 1930 (Address) Rupert Ida

19. Place of Burial, Cremation, or Removal: Albion Cemetery — Date of Burial 6/12/30
20. Undertaker: D. E. Johnson by Paul Bier — Address Twin Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; **keeping a copy of same** for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. **If no physician attended** the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

71451

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S ~~71295~~

Registration District No. 16
Primary Registration District No. 1016
Local Registrar's No. 15

PLACE OF DEATH
County of Lemhi
City of Shoshone
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Boy, — Still Born

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 8 — 1930

7. AGE Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Shoshone Ida
(State or country)

PARENTS

10. NAME OF FATHER Lester Cannon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado
12. MAIDEN NAME OF MOTHER Violet Butler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Lester Cannon
(Address)

15. Filed Aug 9, 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1930, to Aug 1930,
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Still Born
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Not known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? — no
What test confirmed diagnosis?
(Signed) M. D.
, 19 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Ida — Date of Burial: Aug 9 1930
20. Undertaker: B. E. Hickok — Address: Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 1565

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5876

2. FULL NAME Infant Hill

(a) Residence. No. Pocatello St. 504
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 3, 1930.

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Howard P. Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sterling, Idaho.
12. MAIDEN NAME OF MOTHER: Rhoda Homer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Howard P. Hill
(Address) Pocatello, Idaho.

15. Filed 8/5/30., 19.. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 3, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 3, 1930, that I last saw h alive on Stillborn premature, 19.. and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Six months gestation
Acute fulminating appendicitis of mother
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Mother operated Jul 31
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) M. F. Howard M. D.
8/5/30., 19.. (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery, Pocatello, Idaho. | Date of Burial: 8/5/30. 19
20. Undertaker: Arthur W. Hall | Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NCB

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 7150

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5888

208

2. FULL NAME (Infant Scott) Margerett Christine Scott

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 23, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	Still-born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER R. E. Scott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Helen Simonsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant R. E. Scott
(Address) 906 West Center St. Poca., Ida.

15. Filed 8/23/30., 19 J. H. Fanning Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23, 1930, to Aug 23, 1930
that I last saw h alive on Aug 23, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Premature birth - (6 months)
Duration 1 hr.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother - toxemia of pregnancy
severe vomiting.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) O. F. Cell, M. D.
8/23/30., 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	8/23/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

203

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S2182

PLACE OF DEATH

County Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 162

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

344

2. FULL NAME Baby Simons

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Still Born

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Joe Simons

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Luxemburg

12. MAIDEN NAME OF MOTHER: Sophia Bynner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): France

14. Informant: Joe Simons

(Address) Filer

15. Filed Oct. 4, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Intra uterine hemorrhage. Caesarian section performed.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical.

(Signed) H. A. Dwight M.D.

Sept. 5, 1930 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer — Date of Burial: Sept 5 1930

20. Undertaker: F. E. Drake — Address: Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. S 72615

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1604
Local Registrar's No. 298
(No. St Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Douglas
(a) Residence. No. 8 Miles West of Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, 0 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS
10. NAME OF FATHER: Virgil Douglas
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Violet Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or County): ~~Blackfoot~~ Idaho

14. Informant: Virgil Douglas
(Address): R. R. # 2, Boise Idaho

15. Filed 11-24, 1930 W. H. [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to Nov 22, 1930
that I last saw him alive on ....., 19...
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn at term.
Cause unknown.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Koelsch, M. D.
..., 19... (Address) Boise

19. Place of Burial, Cremation, or Removal: Morris Hillcrest Cemetery — Date of Burial: Nov. 24 1930
20. Undertaker: Summers & Kreft — Address: Boise Idaho

10B

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73094 S

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 2140
(No.)
Local Registrar's No. 219

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby — Skinner

(a) Residence. No. Ucon, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 10, 1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS

10. NAME OF FATHER Emil J. Skinner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Soda Springs Idaho
12. MAIDEN NAME OF MOTHER Lena Rasmussen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant Emil J. Skinner
(Address) Idaho Falls Rt 2

15. Filed Nov 1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19..., to , 19...
that I last saw h... alive on , 19...
and that death occurred, on the date stated above, at 4:10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr. H. Anderson, M. D.
November 11, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal: Basalt, Idaho — Date of Burial: Nov 1930

20. Undertaker: Jack G. Ward — Address: Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, **Locomotive Engineer,** Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia: Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FORM V. S. No. 10 Rev. 1-19.

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. S 73453
Local Registrar's No. 2

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara A. Hansinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Child

6. DATE OF BIRTH Nov (Month) 23 (Day) 1930 (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many still hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Leslie Hansinger

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Pearl A. Wagner

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leslie Hansinger
(Address) Minidoka Idaho

15.
Filed Jan. 6 1931 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....,
that I last saw h..... alive on 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Stillborn
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. H. Elmore M. D.
1-6 1931 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery
DATE OF BURIAL Nov 23 1930

20. UNDERTAKER W. J. Goodman
ADDRESS Rupert

MARGIN RESERVED FOR BINDING

ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
ation should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of

186554

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED FEB 5 1930

PLACE OF BIRTH

County of Ada

City of Boise Idaho.

No. 256 114 001-757 St.

St Lukes hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 177851

Registration District No. 2 State File No.

Prim. Registration District No. 1004 Local Registrar's No. 18

FULL NAME OF CHILD Stillbirth - Premature

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child M | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Y | Date of birth Jan (Month) 14 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead Stillborn One

FATHER	MOTHER
FULL NAME Gilbert L. Boysinger	FULL MAIDEN NAME Florence Peters
Residence (Usual place of abode) Boise Rt #4	Residence (Usual place of abode) same
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 50 (Years)	Color or race White Age at last Birthday 38 (Years)
Birthplace South Dakota (City and State or Country)	Birthplace Kansas (City and State or Country)
Occupation Chiropodist	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 7 42 A. M. on the date above stated.

(Signature) A. J. Coats

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address 521 Eastman Bldg

Filed 1/15 1930 W H Rhodes

Registrar.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68993

PLACE OF DEATH

County of Ada.

City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 21

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

B 206

2. **FULL NAME** Baby Boyenger.

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occurred. ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

17851 +

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) January 14th 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
0	0	0	------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER G. L. Boyenger.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland, Mich.

12. MAIDEN NAME OF MOTHER Florence Peters.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant G. L. Boyenger.
(Address) Boise, Idaho.

15. Filed 1-14, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 14th 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19.., to ..., 19..
that I last saw him alive on ..., 19..
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Sick Bronchial Pneumonia Pleurisy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. J. Coats, M. D.
1/14/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/14/30 19
Undertaker Wm. McBratney.	Address Boise, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

464 144 001 255

FEB 5

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Ada

City of Boise

No. ..... St. St Luke's

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 177864

Registration District No. 2 State File No. .....

Prim. Registration District No. 1004 Local Registrar's No. 51

FULL NAME OF CHILD Stillborn Moulton

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate	Date of birth (Month) (Day) (Year)
M				Yes	June 17 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 2 (a) Born alive and now living ~~2~~ 1

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME R. S. Moulton	FULL MAIDEN NAME Violet Sevey
Residence (Usual place of abode) 2811 Pleasanton	Residence (Usual place of abode) 2811 Pleasanton
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 27 (Years)	Color or race White Age at last Birthday 21 (Years)
Birthplace Boise Ida (City and State or County)	Birthplace Boise Ida (City and State or County)
Occupation Laborer	Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 11 30 P. M. on the date above stated.

(Signature) A B Brush

J. W.

(Physician or midwife)

Address Boise Ida

Filed 1-30 1930 W. H. Rhodes R.S. Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

17864 +

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68992

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1094
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22
B

2. FULL NAME Infant Moulton

(a) Residence. No. 2811 Pleasanton Ave. St. 206
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 14 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: Robert S. Moulton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): California
12. MAIDEN NAME OF MOTHER: Violet Lewey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boise Idaho

14. Informant: Mrs J. B. Lewey
(Address) 2811 Pleasanton Ave Boise Idaho

15. Filed 1-15, 1930 C. A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 14 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A. M. Borah, M. D.
Jan, 19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan. 16 1930

20. Undertaker: Summers & Trefs. — Address: Boise Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 177961

PLACE OF BIRTH
County of Blaine
City of Carey
No. ..... St.
993 27 007 231
(If born in hospital or institution give name.)

Registration District No. 57 State File No. .....
Prim. Registration District No. 2025 Local Registrar's No. 4

FULL NAME OF CHILD Stillborn Richards
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Female
Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth
Legitimate? Yes
Date of birth 1 (Month) 17 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 5 (a) Born alive and now living 2
Born alive but now dead — Stillborn 3

FATHER
FULL NAME William Benton Richards
Residence (Usual place of abode) Carey, Idaho
If nonresident, give place and State .....
Color or race White Age at last Birthday 37 (Years)
Birthplace Ogden Utah (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Vermilia Louise Stanford
Residence (Usual place of abode) Carey, Ida
If nonresident, give place and State —
Color or race White Age at last Birthday 35 (Years)
Birthplace Salt Lake City, Utah (City and State or Country)
Occupation Home Keeping

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / Stillborn at 8.30 P. M. on the date above stated.

7 mo. fetus - meningocele
placenta previa - abortal

(Signature) [illegible]
[illegible]
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Hailey, Ida
Filed 2-1 1930 Robert H. Wright
Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

PLACE OF DEATH

County of Blaine

City of Carey

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 57

Primary Registration District No. 2025

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69078

Local Registrar's No. 2

2. FULL NAME J Richards

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or 0 min.

Still born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Carey, Idaho

PARENTS

10. NAME OF FATHER William Benton Richards

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden, Utah

12. MAIDEN NAME OF MOTHER Elvira Louise Stanford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City Utah

14. Informant Tom B. Richards

(Address) Carey, Idaho

15. Filed 2-1, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born - 7 mos fetus -
Mongolian -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Placenta previa

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Wolf, M. D.

1/18, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from **childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull, and consequences** (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 7 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho MAR 3 1930

177961

Mrs. W.D. Richards
Carey

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD no name - stillborn

PLACE OF BIRTH** Carey DATE OF BIRTH Jan. 17, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 2
3. Born alive but now dead
4. Number of children stillborn 3

(Please write plainly)

Information with reference to FATHER

William Denton Richards
(Full name)

Carey, Idaho.
(Residence)

Age at last birthday 37

Ogden, Utah.
(Birthplace)

Farmer & Sheepman
(Occupation)

Information with reference to MOTHER

Vermile Louise Stanford
(Full Maiden name)

Carey, Idaho.
(Residence)

Age at last birthday 34

Salt Lake City, Utah.
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey

C.K. Macey
Special Agent, Bureau of the Census.

RECEIVED FEB 17 1930

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. 815-1150 [illegible] St.

L. D. S. Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S

Registration District No. 73 State File No. 177995

Prim. Registration District No. 2 1 N D Local Registrar's No. 14

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth

Legitimate? yes

Date of birth: Jan. (Month) 15 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 1, (4th mo. gestation)

FATHER

FULL NAME: Freeman Hansen

Residence (Usual place of abode): Idaho Falls

If nonresident, give place and State

Color or race: white Age at last Birthday: 24 (Years)

Birthplace: Tropic Utah (City and State or Country)

Occupation: plumber

MOTHER

FULL MAIDEN NAME: Mabel Jensen

Residence (Usual place of abode): Idaho Falls

If nonresident, give place and State

Color or race: white Age at last Birthday: 23 (Years)

Birthplace: Grover Wyoming (City and State or Country)

Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 12 [illegible] M. on the date above stated.

(Signature) John O. Mellor M.D.

(Physician or midwife)

Address Idaho Falls, Ida.

Filed 1/21 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69110

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

206

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): New Born

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): 1-15-30

7. AGE: Years | Months | Days | If LESS than 1 day, still-born hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): L.D.S. Hospital Idaho Falls Idaho

PARENTS

10. NAME OF FATHER: Mr. Freeman Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tropic Utah
12. MAIDEN NAME OF MOTHER: Mabel Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Grover Wyoming

14. Informant: Freeman Hansen
(Address): Idaho Falls Idaho

15. Filed Jan 17, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 15 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:
Still-born at about 4th mo. gestation
Caused by overwork, and chronic illness
(duration) yrs. mos. ds.
(chronic endocarditis)

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Millar, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Cremation
Date of Burial: 1/17-1930

20. Undertaker: none
Address: —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report **"Typhoid Pneumonia"**); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

753-130-01081

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. ..... St.

L.D.S. Hospital

(If born in hospital or institution give name.)

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S178012

Registration District No. 73 State File No. .....

Prim. Registration District No. 21-70 Local Registrar's No. 39

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	Jan. 30 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 2

FATHER		MOTHER	
FULL NAME	Dewey Peterson	FULL MAIDEN NAME	Violet Hall
Residence (Usual place of abode)	Idaho Falls	Residence (Usual place of abode)	Idaho Falls
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	31	Age at last Birthday (Years)	21
Birthplace (City and State or County)	Canada	Birthplace (City and State or County)	Idaho Falls
Occupation	Coal roof worker	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 1:13 P. M. on the date above stated.

(Signature) A. P. Bodymanson M.D.

Physician

(Physician or midwife)

Address Idaho Falls Idaho.

Filed Feb 12 1930 [illegible]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WHITE PAPER, SUPPLY WITH SUPPLEMENTARY INFORMATION — THIS IS A PERMANENT RECORD

1. In case of twins or more than one child at birth, a separate certificate must be made for each and the number of the child at birth entered.

2. Be sure to write in ink and do not leave blanks.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Print. Registration District No. ..... Local Registrar's No. .....

(If born in hospital or institution give name instead of street and number)

No. ..... St. .....

City of .....

County of .....

FULL NAME OF CHILD .....

(If stillborn, substitute the words "Stillborn" for name of child)

Sex of Child	Twin, Triplet or Quintuplet?	Number in order of birth (Twins, triplets, etc. only)	Length	Date of birth (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmic Neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... (b) Born dead .....

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME
Residence (Usual place of abode)	
Business or occupation	
Color or race	Color or race
Age at last birthday (Years)	Age at last birthday (Years)
Birthplace (City and State or Country)	Birthplace (City and State or Country)
Occupation	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... M. on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19....

*Where there was no attending physician or midwife, then the father, householder, etc., must make this certificate. A stillborn child is one that neither breathes nor shows any evidence of life after birth.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69100

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-2
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

906

2. FULL NAME Baby Peterson (Stillborn)

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan-30-30

7. AGE: Years: Stillbirth; Months; Days; If LESS than 1 day, 0 hrs. or 0 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS
10. NAME OF FATHER: Dewey Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Violet Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho Falls Idaho

14. Informant: Alice L. Anglesey
(Address): Rigby, Ida. RFD 3

15. Filed 1/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 30 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Premature 6 1/2 mos.
Stillborn
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. L. Dougan Jr. M. D.
Jan. 30, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby Idaho — Date of Burial: 1/31 1930

20. Undertaker: [illegible] — Address: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178055

PLACE OF BIRTH

County of Canyon

City of Caldwell

No. 3rd & Gaveliton St.

(If born in hospital or institution give name.)

Registration District No. 3 State File No.

Prim. Registration District No. 1005 Local Registrar's No. 5

FULL NAME OF CHILD Baby Stillbirth Jordan

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth Jan. 19 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 12 (a) Born alive and now living 10

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Orval Jackson Jordan	FULL MAIDEN NAME Ethel Wilson
Residence (Usual place of abode) Caldwell, Ida	Residence (Usual place of abode) Caldwell, Ida
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 49 (Years)	Color or race White Age at last Birthday 38 (Years)
Birthplace Kansas (City and State or Country)	Birthplace Jule Co Kansas (City and State or Country)
Occupation Painter	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 8:30 A. M. on the date above stated.

(Signature) C. R. Whittenberger
Osteopath
(Physician or midwife)

Address Caldwell, Idaho

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed 1-28-1930 John S. Meyers
Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69129

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 9
Primary Registration District No. 1005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

204

2. FULL NAME Baby Jordan

(a) Residence. No. 3rd and Gravelston St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1-20-30

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborn.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell, Idaho

PARENTS

10. NAME OF FATHER Orval Jordan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Ethel Wilson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ~~Kansas~~

14. Informant Orval Jordan
(Address) Caldwell Ida

15. Filed 1-20-, 1930. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to Jan 19, 1930
that I ~~last saw him~~ never saw her alive on Jan 19, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
In utero - probably a week before birth. Skin on body exfoliated.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C. W. Whittenberger M.D.
Jan 21, 1930 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Jan 20 1930

20. Undertaker: Paul L. Case
Address: Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Canyon

City of Caldwell

No. — St.

469 222 014 253

(If born in hospital or institution give name.)

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178066

Registration District No. 3 State File No.

Primary Registration District No. 2005 Local Registrar's No. 16

FULL NAME OF CHILD (Stillborn) Mans

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin ~~Triplet or other~~? Yes and Number in order of birth 1st (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Jan 27 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 2 (a) Born alive and now living None

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Clarence Mans	FULL MAIDEN NAME	Ethel Irene Bethel
Residence (Usual place of abode)	R.F.D. No. 1 Notus	Residence (Usual place of abode)	Notus R.F.D.-1
If nonresident, give place and State	Idaho	If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	29	Age at last Birthday (Years)	28
Birthplace (City and State or Country)	Milgrade Gray	Birthplace (City and State or Country)	Caldwell Idaho
Occupation	Farmer	Occupation	None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 2 P. M. on the date above stated.

(Signature) J. L. Jones

(Physician or ~~midwife~~)*

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Caldwell Idaho

Filed 2-10-1930 John S. Mayes Registrar.

RECEIVED FEB 11 1930

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69130

Registered No. 8

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME (Still Born) Mann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan 22 (Month) 22 (Day) 1930 (Year)

7. AGE: Still Born yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho Canyon Rt 1 Notus

10. NAME OF FATHER: Clarence Mann

11. BIRTHPLACE OF FATHER (State or Country): Hildgrade Ore

12. MAIDEN NAME OF MOTHER: Ethel Irene Bethel

13. BIRTHPLACE OF MOTHER (State or Country): Caldwell Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Clarence Mann
(Address) Notus - Rt 1 D. No 1

15.
Filed 2-10- 1930 John S. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 22 (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1930, to Jan 22 1930 that I last saw h. alive Still Born 1930 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Twin - 30 day Premature
Instrument Delivery

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Gomez M. D.
Jan 27 19..... (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: at Home

DATE OF BURIAL: 1-23 1930

20. UNDERTAKER: Mathews & Friends

ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Franklin

City of Clifton Ida

No. ..... St.

317 104 021 766

(If born in hospital or institution give name.)

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178154

Registration District No. 27 State File No. .....

Prim. Registration District No. 216 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male					Jan 4 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME George Merrill Aspinwall	FULL MAIDEN NAME Melda Kofred
Residence (Usual place of abode) Clifton Ida	Residence (Usual place of abode) Clifton Ida
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 23 (Years)	Color or race White Age at last Birthday 20 (Years)
Birthplace Farmington (City and State or County)	Birthplace Clifton Ida (City and State or County)
Occupation Station Agent O. S. L.	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 10 30 A. M. on the date above stated.

(Signature) Eugene Morley

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Preston Ida

Filed Jan 7 1930 A. R. Curtis

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

REC FEB 10 1930

PLACE OF BIRTH

County of Franklin

City of Preston, Ida

No. ..... St.

335 127 021 255

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178164

Registration District No. 27 State File No. .....

Prim. Registration District No. 2119 Local Registrar's No. .....

FULL NAME OF CHILD Still Born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male			yes	Jan 27 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 15 (a) Born alive and now living 13

Born alive but now dead I Stillborn I

FATHER	MOTHER
FULL NAME Harris A Stephenson	FULL MAIDEN NAME Saphrona Bennett
Residence (Usual place of abode) Preston, Ida	Residence (Usual place of abode) Preston, Ida
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 53 (Years)	Color or race white Age at last Birthday 52 (Years)
Birthplace Utah (City and State or County)	Birthplace Richmond, Utah (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / Stillborn} at 1-50 A. M. on the date above stated.

(Signature) G. W. Stokes

M.D.

(Physician or midwife)

Address Preston Idaho RR, Box

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed .....

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State's File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

PLACE OF BIRTH

County of .....

City or .....

No. ..... St. .....

(If born in hospital or institution give name)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillborn" for name or sex)

Sex of Child	Twin or Triplet or other	Number and order of birth (To be answered only in case of twins or triplets)	Legitimate?	Date of birth	
				..... (Month)	19..... (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... (b) Stillborn .....

	FATHER	MOTHER
FULL NAME		
Residence (Usual place of abode)		
If non-resident, give place and State		
Color or race	Age at last Birthday (Years)	Color or race / Age at last Birthday (Years)
Birthplace (City and State or Country)		Birthplace (City and State or Country)
Occupation		Occupation

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... M. on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WHITE PLAINS, NEW YORK—THIS IS A PROMISSORY RECORD
N. B.—In case of twins then one child of a pair is entered in order of birth, and the number and the number of twin pairs.
For each and the number of twin pairs.

FORM V. S. No. 1-15 REGISTERED FEB 10 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69191

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin

City of Preston Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

2. FULL NAME Still born

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6. DATE OF BIRTH Jan 27 (Month) (Day) 1930 (Year)

7. AGE — Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Preston, Idaho

10. NAME OF Father Harris A. Stephenson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sophrona Bennett

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harris A. Stephenson
(Address) Preston Idaho

15. Filed June 30 1930 A. P. Miller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1930 to Jan 27 1930, that I last saw him alive Born dead 19, and that death occurred on the date stated above, at 1 50 A. M.

The CAUSE OF DEATH* was as follows: Prolapse of Umbilical Cord — Born dead — at 1 50 A M of Jan 27 - 1930

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. W. Stokes M. D.

Jan 28 1930. (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Preston Idaho — **DATE OF BURIAL** Jan 30 1930

20. UNDERTAKER M. W. Hendricks — **ADDRESS** Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

69260

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178260

PLACE OF BIRTH
County of Nez Perce
City of Gibbs
No. ..... St.
554 2 10 028 713
(If born in hospital or institution give name.)

Registration District No. 30 State File No.
Prim. Registration District No. 1050 Local Registrar's No. 14

FULL NAME OF CHILD Leona Beth Vedder
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate	Date of birth (Month) (Day) (Year)
Female				Yes	1 - 10 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth I (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Leonard Vedder	FULL MAIDEN NAME Beth Potter
Residence (Usual place of abode) Gibbs, Ida	Residence (Usual place of abode) Gibbs, Ida
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 28 (Years)	Color or race white Age at last Birthday 20 (Years)
Birthplace Berlin Wisc (City and State or Country)	Birthplace Lind Wash (City and State or Country)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 11:30 P. M. on the date above stated.

(Signature) Harold J. Sturges M.D.
Phys.
(Physician or midwife)

Address Council, Adams, Ida

Filed 2-7 1930 H. J. Sturges
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible] OF BIBLE [illegible]
[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69260

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 21

(No. 1612)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leona Beth Vedder.

(a) Residence. No. St. Pibbs. Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930-1-10.

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Ida.

PARENTS

10. NAME OF FATHER Leonard Vedder

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Burlyn, Wis.

12. MAIDEN NAME OF MOTHER Beth Potter

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Wash.

14. Informant Leonard Vedder
(Address) Pibbs, Id.

15. Filed 2/11, 1930. S. J. Sturgeo-
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 11 0 0 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum
due to prolonged difficult
labor (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) Harold J. Sturgeo M. D.

Jan 12, 1930 (Address) Cda Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem C'd'A	1-12 1930

20. Undertaker	Address
Funeral Home	C'd'A

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Latah

City of

No. — St.

RECEIVED FEB 12 1930

893-212 029-285

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178287

Registration District No. 65 State File No.

Prim. Registration District No. 2145 Local Registrar's No.

FULL NAME OF CHILD Stillborn Infant Hill

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female	—	—	Yes	Jan 12 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead — Stillborn 1

FATHER	MOTHER
FULL NAME Orville J. Hill	FULL MAIDEN NAME Una Shepard
Residence (Usual place of abode) Latah Co. Ida	Residence (Usual place of abode) Latah Co. Ida
If nonresident, give place and State —	If nonresident, give place and State —
Color or race White Age at last Birthday 46 (Years)	Color or race White Age at last Birthday 33 (Years)
Birthplace Wash (City and State or Country)	Birthplace Mo (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 1 30 A. M. on the date above stated.

(Signature) E. K. Wolfe M.D.

(Physician or midwife)

Address Potlatch Wash

Filed Jan 14 1930 D. M. Thompson Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69268

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Troola
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Hill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 12 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER O. J. Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington
12. MAIDEN NAME OF MOTHER Shepard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant O. J. Hill
(Address) Palouse Wash

15. Filed Jan 14, 1930 E. J. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19—, to — 19—
that I last saw him alive on — 19—
and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:
Still Born.
— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) E. K. Wolf M. D.
Jan 13, 1930 (Address) Palouse Wa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Troola Ida | Date of Burial: Jan 13 1930

20. Undertaker: J. M. Irwin | Address: Palouse Wash

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. **If the information cannot be secured, it should be plainly stated unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH FEB 10 1930

County of Nez Perce

City of Lewiston

No. 54½ 220 035 766 St.

St. Joseph's

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178355

Registration District No. 96 State File No.

Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female		5th	Yes	Jan. 20 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 5th (a) Born alive and now living Three

Born alive but now dead One Stillborn One

FATHER	MOTHER
FULL NAME Walter Willis Edwards	FULL MAIDEN NAME Marie George
Residence (Usual place of abode) 1240 Idaho St	Residence (Usual place of abode) 1240 Idaho St
If non-resident, give place and State Lewiston, Ida	If non-resident, give place and State Lewiston Ida
Color or race White Age at last Birthday 41 (Years)	Color or race White Age at last Birthday 32 (Years)
Birthplace Iowa (City and State or County)	Birthplace Minn. (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 11:30 P. M. on the date above stated.

(Signature) W. O. Clark

Physician

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Lewiston Ida

Filed Jan 1 1930 Susan E Bruce

Registrar.

.....

.....

(Physician or midwife)

Address .....

Filed.....19..... ....

Registrar.

. . . . evidence of life after birth. } . . breathes nor

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69307

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Wilma Jean Edwards
(a) Residence. No. 1240 Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): 1/21/1930
7. AGE Years —— Months —— Days —— If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS
10. NAME OF FATHER: W. A. Edwards
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Marie George
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn

14. Informant: W. W. Edwards
(Address): Lewiston Idaho.
15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 21st 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 21, 1930
that I last saw h. alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Still Born
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Unknown
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W O Clark M. D.
1/22, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho — Date of Burial: 1/23 1930
20. Undertaker: Brown-Wunn & — Address: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Ada

City of Boise

No. 1726 Howe St.

430 2-50 446

(If born in hospital or institution give name.)

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 78574

Registration District No. 2 State File No.

Prim. Registration District No. 1864 Local Registrar's No. 88

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth 2 - 15 - 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Leonard E. Ulrich	FULL MAIDEN NAME Charlotte Moore
Residence (Usual place of abode) 1726 Howe St. So. Boise	Residence (Usual place of abode) 1726 Howe St. So. Boise
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 42 (Years)	Color or race White Age at last Birthday 43 (Years)
Birthplace New York (City and State or County)	Birthplace Minnesota (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 2.45 A.M. on the date above stated.

(Signature) J. N. Bratton M.D.

Physician
(Physician or midwife)

Address Boise Idaho

Filed 2-17 1930 W. H. Rhodes
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF [illegible]

DEPARTMENT OF [illegible]

BUREAU OF VITAL [illegible]

(Place of birth)

Registration District No. ..... State File No. .....

Phys. Reg. ..... on District No. ..... Local Registrar's No. .....

CERTIFICATE OF CHILD

(If children, substitute the word "Children" for name of child)

Place of birth (County or parish)	Twin, triplet, or quadruplet?	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	19

(Use separate line for each child)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Complete or child of this mother including present birth: ..... (a) Born alive and now living

Born alive but now dead

Stillborn

	FATHER	MOTHER
FULL NAME		
FULL MAIDEN NAME		
Residence (last place of abode)		
Residence (Street and number)		
Residence (City or town)		
Residence (County)		
Residence (State or country)		
Color or race	Age at last birthday (Years)	Age at last birthday (Years)
Birthplace (State or country)		
Occupation		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at ..... on the date above stated.

(Signature) .....

(Address) .....

Date .....

(Signature of attending physician or midwife)

Or, if born without a physician or midwife in attendance, then the statement of the father, householder, or other person having knowledge of the birth, or of the mother, if able to give the required information, should be made on the reverse side hereof.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69410

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. 1726 Howe St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

2. FULL NAME Baby Ulrich

(a) Residence. No. Boise, Idaho St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.) - - - - -

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of - - - - - -

6. DATE OF BIRTH (month, day and year)

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Ida.

PARENTS

10. NAME OF FATHER Leonard E. Ulrich

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Charlotte Moore

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Minn.

14. Informant (Address) L. E. Ulrich

15. Filed 2-15 1930 U. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 15 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1930 to Feb 15 1930 that I last saw him alive on Still Born 1930 and that death occurred, on the date stated above, at 2:45 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Probably Electrical shock of Mother about two wk ago

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Don't Know

Macerated Foetus

....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. W. Bradbury, M. D.

Feb 15 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal E. M. Ulrich place — Date of Burial 2-15 1930

20. Undertaker L. E. Ulrich — Address Barber Road 1726 Howe

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of [redacted]

City of Boi[redacted]

No. [redacted] St. [redacted]

St Alphonsus Hosp

(If born in hospital or institution give name.)

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

~~CERTIFICATE OF BIRTH~~ S 178591

Registration District No. 2 State File No.

Prim. Registration District No. 1004 Local Registrar's No. 71

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth 1 - 26 - 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME: Albino Savala	FULL MAIDEN NAME: Pilar Naveran
Residence (Usual place of abode): 303 Bannock St.	Residence (Usual place of abode): 303 Bannock St.
If nonresident, give place and State:	If nonresident, give place and State:
Color or race: White Age at last Birthday: 40 (Years)	Color or race: White Age at last Birthday: 38 (Years)
Birthplace: Spain (City and State or Country)	Birthplace: Spain (City and State or Country)
Occupation: Sheepherder	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / ~~Stillborn~~} at 8 30 A. M. on the date above stated.

(Signature) T. N. Brayton M. D.

Physician (Physician or midwife)

Address Boise Idaho

Filed 2-10 1930 W. H. Rhode Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68982

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hos)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

2. FULL NAME Baby Sabala 306 B

(a) Residence. No. 303 Bannock St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): Jan. 26 - 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.: Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise, Ida

PARENTS

10. NAME OF FATHER: Albino Sabala

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Pilar Navarro

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Albino Sabala
(Address): Boise, Ida

15. Filed 1-30, 1930 W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Born dead ~~Malnutrition~~ Jan (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 26, 1930, that I last saw him ~~alive~~ on Never, 19.., and that death occurred, on the date stated above, at several days before birth.

The CAUSE OF DEATH* was as follows: Probably Hypertension of Mother & Premature Loosening of Placenta (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Hypertension of Mother (duration) unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Idaho

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. N. Brassfan, M. D.

Jan 27, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery | Date of Burial: 1/28 1930.

20. Undertaker: Schreiber & W. Cann | Address: Boise, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from **childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

313-22 0 C 3 553 de Brotherson

PLACE RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178632

County of Bannock

City of Pocatello

No. ..... St.

Pocatello Gen'l

(If born in hospital or institution give name.)

Registration District No. 28 State File No.

Prim. Registration District No. 2161 Local Registrar's No. 9674

FULL NAME OF CHILD (Stillbirth) Call

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				yes	Feb 20 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER		MOTHER	
FULL NAME	Phillip C. Call	FULL MAIDEN NAME	Hazel Nelson
Residence (Usual place of abode)	Pocatello Ida	Residence (Usual place of abode)	Pocatello Ida
If non-resident, give place and State	Brigham Utah	If non-resident, give place and State	Brigham Utah
Color or race	White Age at last Birthday 26 (Years)	Color or race	White Age at last Birthday 26 (Years)
Birthplace (City and State or County)	Chesterfield Ida	Birthplace (City and State or County)	Richfield Utah
Occupation	Dentist	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive / Stillborn at 10:27 p. M. on the date above stated.

(Signature) Ella Gro Rees

(Physician or midwife)

Address Pocatello

Filed 3/11 1930 J. A. Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69434

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 161
(No. Pocatello, Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5766

2. FULL NAME Infant Coll

(a) Residence. No. 102 Princess apts
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 20, 1930

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS

10. NAME OF FATHER: Philip C. Coll.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Chesterfield Ida.
12. MAIDEN NAME OF MOTHER: Hazel Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Richfield, Utah

14. Informant: Phillip C. Coll
(Address): Pocatello Idaho

15. Filed Feb 20 1930 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-20, 1930, to 2-20, 1930
that I last saw her alive on 2-20, 1930
and that death occurred, on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Premature (7 mo)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Atrophia placenta
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Brothers M. D.
Feb, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida. | Date of Burial: Feb 21, 1930

20. Undertaker: N. L. McHan | Address: Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE RECEIVED MAR 12 1930

County of Bannock

City of Pocatello

No. 542 So Garfield

Pac. Sem. Hosp.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Wm Groom

CERTIFICATE OF BIRTH

S 178651

Registration District No. 28 State File No.

Prim. Registration District No. 216 Local Registrar's No. 9655

FULL NAME OF CHILD Stillbirth McFarland

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male	—		—	Yes	Feb 2 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Charles M. McFarland	FULL MAIDEN NAME	Beulah Maggie Hargraves
Residence (Usual place of abode)	Pocatello	Residence (Usual place of abode)	Pocatello
If non-resident, give place and State	—	If non-resident, give place and State	—
Color or race	White	Color or race	White
Age at last Birthday (Years)	37	Age at last Birthday (Years)	20
Birthplace (City and State or County)	Ft Townsend Wash	Birthplace (City and State or County)	Inkom, Ida
Occupation	Oil Dr	Occupation	Home Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 8 P. M. on the date above stated.

(Signature) C. P. Groom
Physician
(Physician or midwife)

Address Pocatello, Idaho

Filed 3/11 1930 [illegible]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...very item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ...d state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69049

Local Registrar's No. 5 7 26

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No. 161

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Jack McFarland

(a) Residence. No. Pocatello, Idaho. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Febuary 2, 1930.

7. AGE Years	Months	Days	If LESS than 1 day,
Still Born			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Charles M. McFarland

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington

12. MAIDEN NAME OF MOTHER Beulah M. Hargrave

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Inkom, Idaho.

14. Informant Charles M. McFarland

(Address) 542 South Garfield Ave. Poca. Ida.

15. Filed 2/4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febuary 2, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/2, 1930, to 2/2, 1930 that I last saw h[illegible] alive on 2/2, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/3/1930, 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	2/3/30. 19

20. Undertaker	Address
Arthur W. Hall	Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

3191 02 003 032

PLACE OF BIRTH

County of ~~Bannock~~ RECEIVED MAR 12 1930

City of Pocatello

No. 284 - Washington - Res.

Pocatello Sanit.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 28 State File No. 178652

Prim. Registration District No. 2161 Local Registrar's No. 9654

FULL NAME OF CHILD Stillbirth Larsen

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	Feb. 2 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead Stillborn

FATHER		MOTHER	
FULL NAME	Carl Oscar Larsen	FULL MAIDEN NAME	Hanna Marie Olsen
Residence (Usual place of abode)	Pocatello, Ida	Residence (Usual place of abode)	Pocatello, Ida
If nonresident, give place and State	" "	If nonresident, give place and State	" "
Color or race	White	Color or race	White
Age at last Birthday (Years)	46	Age at last Birthday (Years)	42
Birthplace (City and State or Country)	Sweeden	Birthplace (City and State or Country)	Omaha Neb.
Occupation	Foreman Shop	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 5:45 P. M. on the date above stated.

(Signature) D. C. Ray

(Physician or midwife)

Address Pocatello

Filed 3/1 1930 M Fanning Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

4/15 211 003 165

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. ..... St.

Poc. Gen. Hospital
(If born in hospital or institution give name.)

MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 28 State File No. 178664

Prim. Registration District No. 2161 Local Registrar's No. 9642

FULL NAME OF CHILD Stillbirth Daniels (Vera Betty)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female	—	—	Yes	Jan. 11 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Oscar La Mar Daniels	FULL MAIDEN NAME	Vera Betty Jones
Residence (Usual place of abode)	Pocatello	Residence (Usual place of abode)	Pocatello
If nonresident, give place and State		If nonresident, give place and State	—
Color or race	White	Color or race	White
Age at last Birthday (Years)	25	Age at last Birthday (Years)	20
Birthplace (City and State or Country)	Malad, Idaho	Birthplace (City and State or Country)	Salt Lake City, Utah
Occupation	Stockman	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 3:50 P. M. on the date above stated.

(Signature) D. C. Ray
(Physician or midwife)

Address Pocatello

Filed 3/1 1930 [illegible]
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69037

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5741

206

2. FULL NAME Infant Daniels

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 11, 1930.

7. AGE: Years: Still Born; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: LaMar Daniels
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Malad, Idaho,
12. MAIDEN NAME OF MOTHER: Vera Betty Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: LaMar Daniels
(Address): Pocatello, Idaho.

15. Filed 1-12, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 11, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to 1-11, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Died in utero 2 days
Forceps Pressure on Cord
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. C. Ray, M. D.
1/14, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad, Idaho.
Date of Burial: 1/13/30 19

20. Undertaker: ARTHUR W. HALL
Address: POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAR 13 1930

County of Blaine

City of Carey

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178726

Registration District No. 57 State File No. .....

Prim. Registration District No. 2025 Local Registrar's No. 9

FULL NAME OF CHILD Milo Eugene Atwood (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	2 - 16 - 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead — Stillborn 1

FATHER		MOTHER	
FULL NAME	Alvin Eugene Atwood	FULL MAIDEN NAME	Mary Elizabeth Briggs
Residence (Usual place of abode)	Carey, Idaho	Residence (Usual place of abode)	Carey, Idaho
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White Age at last Birthday 23 (Years)	Color or race	White Age at last Birthday 24 (Years)
Birthplace	Bellevue, Idaho (City and State or Country)	Birthplace	Mazamit Fork Wash (City and State or Country)
Occupation	Laborer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 10:30 a M. on the date above stated.

(Signature) E. W. Fox

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Hailey, Idaho

Filed 3 - 1 1930 Bert H. Wright

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69472

PLACE OF DEATH

County of Blaine

City of Carey

CERTIFICATE OF DEATH

Registration District No. 57

Primary Registration District No. 2025

Local Registrar's No. 7

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Milo Eugene Attwood

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Still born

7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Carey, Idaho

PARENTS

10. NAME OF FATHER: Albion Eugene Attwood

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Weybourg, Idaho

12. MAIDEN NAME OF MOTHER: Mary Elizabeth Briggs

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bennet Fort Utah

14. Informant: Albion E. Attwood
(Address): Carey Idaho

15. Filed 2-1, 1930 Robert H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Still born - Full term
Placental Hemorrhage
Preceding birth - marginal
Placental Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

2/17, 1930 (Signed) [illegible], M. D.
(Address) Carey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carey, Ida — Date of Burial: 2-17 1930

20. Undertaker — Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull,** and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH MAR 7 1930

County of Bonner

City of Sandpoint

No. 2211 3 00 7 66 St.

Parnell Hospital
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178737

Registration District No. 76 State File No.

Prim. Registration District No. 2155 Local Registrar's No. 22

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth February 13 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 1%

Number of child of this mother, including present birth 5th. (a) Born alive and now living Four

Born alive but now dead Stillborn One

FATHER	MOTHER
FULL NAME Earl Brittain	FULL MAIDEN NAME Kathleen Powers
Residence (Usual place of abode) Dover, Idaho.	Residence (Usual place of abode) Dover, Idaho.
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 33 (Years)	Color or race White Age at last Birthday 29 (Years)
Birthplace Seattle, Washington (City and State or Country)	Birthplace Rosslyn B.C. Canada (City and State or Country)
Occupation Telegraph Operator	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 6.30 P.M. on the date above stated.

(Signature) J. B. Evans

Physician
(Physician or midwife)

Address Sandpoint, Ida.

Filed Mar 3 1930 Viola Allen Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69481

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2010

2. FULL NAME Infant Brittain

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 15, 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho

PARENTS

10. NAME OF FATHER Earl R. Brittain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Seattle Wash
12. MAIDEN NAME OF MOTHER Kathleen Powers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rossland B.C.

14. Informant Earl R. Brittain
(Address) Seattle Washington

15. Filed Feb. 16, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15th, 1930, to Feb. 15, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Still birth in 8th month of Gestation
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Placenta Praevia
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. B. Graves, M. D.
2-15th, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sunnyside Cemetery — Date of Burial: Feb. 16, 1930
20. Undertaker: Moon Mortuary — Address: Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAR 7 1930

County of Bonner

City of Sandpoint

No. 724 N. Fresh Ave.

251-121-069-426

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 76 State File No. 178738

Prim. Registration District No. 2155 Local Registrar's No. 21

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth

Legitimate? Yes

Date of birth: 2 (Month) 21 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 1%

Number of child of this mother, including present birth: Two (a) Born alive and now living: 1

Born alive but now dead: Stillborn: 1

FATHER	MOTHER
FULL NAME: Mr Eddie Beal	FULL MAIDEN NAME: Grace Moore
Residence (Usual place of abode): Sandpoint	Residence (Usual place of abode): Sandpoint
If nonresident, give place and State:	If nonresident, give place and State:
Color or race: White Age at last Birthday: 22 (Years)	Color or race: White Age at last Birthday: 20 (Years)
Birthplace: Washington (City and State or Country)	Birthplace: Michigan (City and State or Country)
Occupation: Sign Painter	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9 30 P. M. on the date above stated.

(Signature) Wm F. Tyler

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Sandpoint, Ida.

Filed Mar 3 1930 Viola Allen Deputy Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 60477

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. 724 Forest Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Stillborn Beal

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb. 21. 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sandpoint Idaho

PARENTS

10. NAME OF FATHER: Glen Beal
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Washington
12. MAIDEN NAME OF MOTHER: Grace Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ~~Town of Pine~~ Michigan

14. Informant: Mrs Ruth Flanagan
(Address): Sandpoint

15. Filed Feb 22 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Still Born Feby 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 21, 1930, to Feby 21, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9:30 P.m.
The CAUSE OF DEATH* was as follows:

6½ month foetus
still born. Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Wm F. Tyler, M. D.
Feby 22, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Seneca Quoleen Cem. Laclede, Idaho — Date of Burial: Feb. 22 1930

20. ~~Undertaker~~: Wm Ruth Flanagan — Address: Laclede Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 7 1930

PLACE OF BIRTH

County of Bonner

City of Sandpoint, Ida.

No. St.

Parnell Hospital
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178741

Registration District No. 78 State File No.

Prim. Registration District No. 2155 Local Registrar's No. 16

FULL NAME OF CHILD Stillborn Bonar
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child female | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth Feb 16 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead Stillborn 2

FATHER	MOTHER
FULL NAME Charles Bonar	FULL MAIDEN NAME Eva ~~Grace~~ Colville
Residence (Usual place of abode) Sandpoint (rural)	Residence (Usual place of abode) Sandpoint (rural)
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 40 (Years)	Color or race White Age at last Birthday 29 (Years)
Birthplace Belleville W. Virginia (City and State or Country)	Birthplace Trenton, Mo (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 10:30 P. M. on the date above stated.

(Signature) Floyd E Wendle M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Sandpoint, Idaho

Filed Mar 3 1930 Viola Allen Deputy Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE [redacted]

County of .....

(City) .....

No. ..... St. .....

(Hospital or institution)

IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Regis-tration District No. ..... State File No. .....

(For registration District No. ..... local registrar's No. .....

FULL NAME OF CHILD .....

(If given, substitute the word "Stillborn")

Sex of Child	Twin, triplet, or other? (To be answered only in case of multiple birth)	Legitimate?	Date of birth	19.. (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present child: (a) Born alive and now living ..... (b) Born alive and now dead ..... (c) Stillborn .....

FATHER

Residence (Usual place of abode) ..... **Residence (Usual place of abode)** .....

If nonresident, give place and State ..... If nonresident, give place and State .....

Color or race ..... Age at last Birthday ..... Color or race ..... Age at last Birthday .....

(Years) (Years)

Birthplace ..... Birthplace .....

(City and State or Country) (City and State or Country)

Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (born alive / stillborn) at ..... M. on the date above stated.

(Signature) .....

(Degree or title)

Address .....

Filed ..... 19..

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WHITE PLAINLY WITH INDELIBLE INK — DO NOT FOLD

Type or print in ink. Do not use pencil. Be careful to spell names correctly. Use full words. Do not abbreviate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69480

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

706

2. FULL NAME Infant Bonar.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 16, 1930.

7. AGE Years Months Days: Stillbirth
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

PARENTS

10. NAME OF FATHER Charles Bonar
11. BIRTHPLACE OF FATHER (city or town) Bellville
(State or Country) W. Virginia
12. MAIDEN NAME OF MOTHER Ossie Colville
13. BIRTHPLACE OF MOTHER (city or town) Trenton
(State or Country) Mo.

14. Informant Charles Bonar
(Address) Sandpoint, Ida

15. Filed Feb. 18, 1930. Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Stillbirth.
~~[illegible]~~ 7 months gestation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Placenta Previa
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Floyd G. Wendle, M. D.
Feb. 18, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Vincent Cemetery
Date of Burial: Feb. 18 1930

20. Undertaker: Moon Mortuary
Address: Sandpoint Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Clearwater

City of Orofino, Ida.

No. ..... St.

256 217 018 255

(If born in hospital or institution give name.)

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 90 State File No. 178885

Prim. Registration District No. 2187 Local Registrar's No. 20

FULL NAME OF CHILD Unnamed Benedict

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? (To be answered only in event of plural births) | and | Number in order of birth | Legitimate? Yes | Date of birth Feb. 17 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Ezra B. Benedict Jr.	FULL MAIDEN NAME Pattie Seeck
Residence (Usual place of abode) Orofino	Residence (Usual place of abode) Orofino
If nonresident, give place and State	If nonresident, give place and State
Color or race W Age at last Birthday 40 (Years)	Color or race W Age at last Birthday 44 (Years)
Birthplace Minnesota (City and State or Country)	Birthplace Minnesota (City and State or Country)
Occupation Rancher	Occupation At home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 7:00 A. M. on the date above stated.

(Signature) E B Benedict Jr.
(Father)
(~~Physician or Midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Orofino, Idaho

Filed 3/15 19.... H. E. Shaw
Registrar.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69551

PLACE OF DEATH

County of Canyon
City of Caldwell, Ida.

CERTIFICATE OF DEATH

Registration District No. 90
Primary Registration District No. 21 87
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 18

2. FULL NAME Minnamed Benedict, male

(a) Residence. No. Caldwell, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years: Fullborn; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Caldwell, Idaho

PARENTS
10 NAME OF FATHER Ezra B. Benedict, Jr.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Minnesota
12 MAIDEN NAME OF MOTHER Hattie Seely
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant E. B. Benedict Jr.
(Address)

15 Filed 2/15, 1930 H. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 (Month) 17 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis?.....
(Signed) Had no Doctor, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Caldwell Ida
Date of Burial: 2/19 19

20. Undertaker: H. A. Shaw
Address: Caldwell

178857 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. if the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Franklin RECEIVED MAR 8 1930

City of Preston Idaho

No. ..... St. 194-126-021-284

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178994

Registration District No. 27 State File No. .....

Prim. Registration District No. 2119 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	Feb. 26 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Wm. J. Armstrong	FULL MAIDEN NAME Ida Shumway
Residence (Usual place of abode) Pocatello Ida	Residence (Usual place of abode) Pocatello Ida
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 23 (Years)
Birthplace Ida (City and State or County)	Birthplace Utah (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 1:00 P. M. on the date above stated.

(Signature) J. R. Cutler

Physician

(Physician or midwife)

Address Preston Idaho

Filed Feb. 27 1930 J. R. Cutler

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69571

PLACE OF DEATH
County of Franklin
City of Preston Ida

Registration District No. 27
Primary Registration District No. 2119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 26, 1930

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston, Idaho

PARENTS

10. NAME OF FATHER Wm. T. Armstrong
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Ida Shumway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Wm. T. Armstrong
(Address) Pocatello Idaho

15. Filed Feb. 27, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) (Day) (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Stillborn
Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. R. Butler M. D.
Feb. 27, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Ida
Date of Burial: 2-27 1930

20. Undertaker
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

815 120 329.494

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 178993

PLACE OF BIRTH
County of Latah
City of Troy
No. ..... St. .....
(If born in hospital or institution give name.)

Registration District No. 64 State File No. .....
Prim. Registration District No. 2144 Local Registrar's No. .....

FULL NAME OF CHILD Stillbirth Hanson
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate Yes | Date of birth Feb. 20 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 5th (1) Born alive and now living 4
Born alive but now dead 0 Stillborn One

FATHER	MOTHER
FULL NAME Henry John Hanson	FULL MAIDEN NAME Mildred Dennick
Residence (Usual place of abode) Troy Idaho	Residence (Usual place of abode) Troy Idaho
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 35 (Years)	Color or race White Age at last Birthday 32 (Years)
Birthplace Macoupin (City and State or County)	Birthplace Pennsylvania (City and State or County)
Occupation Lumber Mill Operator	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 3 50 p. M. on the date above stated.

(Signature) Roy A. Meyer M.D.
Physician
(Physician or midwife)

Address Troy Idaho

Filed Feb 28 1930 Lucy M. Pickett
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69611

PLACE OF DEATH

County of Latah

City of Troy

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME (Still Birth) Hanson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years: Still born; Months; Days: 0; If LESS than 1 day, 0 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Troy Ida

PARENTS

10 NAME OF FATHER: Henry John Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri

12 MAIDEN NAME OF MOTHER: Mildred Dimmick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant: H. J. Hanson
(Address): Troy Ida

15 Filed: Feb 20, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 20. (Day) 1930 (Year)

17 Feb. 20. 1930 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930 to Feb. 20, 1930 that I last saw her alive on Stillbirth, 19 and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:
Stillbirth
asphyxia (breech presentation).
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. G. Meyer, M. D.
Feb 20, 1930. (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Westdale cem — Date of Burial: Feb 20 1930

20. Undertaker: John J. Pickard — Address: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

551-115030-436

PLACE OF BIRTH RECEIVED FEB 19 1930

County of Fremont

City of Carmen

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 179011

Registration District No. 41 State File No.

Prim. Registration District No. 2116 Local Registrar's No.

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	January 15 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth One (a) Born alive and now living None

Born alive but now dead Stillborn this one

FATHER		MOTHER	
FULL NAME	Ernest Neal	FULL MAIDEN NAME	Katie McFarland
Residence (Usual place of abode)	Carmen	Residence (Usual place of abode)	Carmen
If nonresident, give place and State		If nonresident, give place and State	
Color or race	wh	Color or race	wh
Age at last Birthday (Years)	28	Age at last Birthday (Years)	18
Birthplace (City and State or Country)	Idaho	Birthplace (City and State or Country)	Idaho
Occupation	Rancher	Occupation	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / Stillborn} at 6 a.m. on the date above stated.

(Signature) F S Mugler M D
(Physician or midwife)

Address Salmon Idaho

Filed Feb 11 1930 Clio E Bellamy
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAR 11 1930

County of Minidoka

City of Paul

No. ..... St.

955 107 034 1366

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179042

Registration District No. 19 State File No.

Prim. Registration District No. 9015 Local Registrar's No. 32

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth March (Month) 7 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Willis S. Reed	FULL MAIDEN NAME Nellie May Coon
Residence (Usual place of abode) Paul Ida.	Residence (Usual place of abode) Paul. Ida.
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 30 (Years)	Color or race white Age at last Birthday 30 (Years)
Birthplace Mo. (City and State or Country)	Birthplace Indiana (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 10 20 A. M. on the date above stated.

(Signature) Ella E. Elzmore

MD.
(Physician or midwife)

Address Rupert, Idaho

Filed 3-9 1930 Ella E. Elzmore
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

433 114 042 432

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. ..... St.

T. F. Cottage Hospital

(If born in hospital or institution give name.)

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

179150

Registration District No. 87 State File No. .....

Prim. Registration District No. 2082 Local Registrar's No. .....

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? | and | Number in order of birth (To be answered only in event of plural births) | **Legitimate?** Yes | **Date of birth** Feb 14 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Arthur T. McCreary	FULL MAIDEN NAME Hope McKinley
Residence (Usual place of abode) Kimberly Idaho	Residence (Usual place of abode) Kimberly Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race W Age at last Birthday 24 (Years)	Color or race W Age at last Birthday 24 (Years)
Birthplace Philadelphia Kan. (City and State or County)	Birthplace Oceola Co. Iowa (City and State or County)
Occupation Laborer - Farm	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } **at** 3 40 M. **on the date above stated.**

(Signature) J M Davis

(Physician or midwife)

Address Kimberly, Idaho

Filed 3-5-1930 Elizabeth Smith Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69696

PLACE OF DEATH
County of Twin Falls
City of ..... 11 ..... 11 .....

Registration District No. .....
Primary Registration District No. .....
(No. St. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Baby McCreary

(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14 1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls Ida.

PARENTS

10. NAME OF FATHER Arthur F. McCreary
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Hope McKinley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Arthur F. McCreary
(Address) Kimberly Ida

15. Filed 3-6, 1930 E. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 - 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-14, 1930, to 2/14, 1930
that I last saw h..... alive on Stillborn, 19..
and that death occurred, on the date stated above, at 3 a, m.
The CAUSE OF DEATH* was as follows:
Intra-Uterine
Strangulation
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) J. R. Deans, M. D.
2/14, 1930 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer | Date of Burial: Feb. 15 1930

20. Undertaker: J. Norman | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MAR 11 1930

PLACE OF BIRTH

County of Valley

City of Cascade

No. 847 211 043 733 St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 25 State File No. 179189

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD Stillborn - Infant Hughes

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? (To be answered only in event of plural births) | and Number in order of birth | Legitimate? Yes | Date of birth Feb 11 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 2

FATHER	MOTHER
FULL NAME Rufus A Hughes	FULL MAIDEN NAME Zadie Carrie Allen
Residence (Usual place of abode) Cascade	Residence (Usual place of abode) Cascade
If nonresident, give place and State Idaho	If nonresident, give place and State Idaho
Color or race White, Age at last Birthday 54 (Years)	Color or race White Age at last Birthday 39 (Years)
Birthplace Springfield Mo. (City and State or Country)	Birthplace Sherman Texas (City and State or Country)
Occupation Lumberjack	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 12 30 a M. on the date above stated.

(Signature) Roscoe C Ward M.D.

*(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Cascade Idaho

Filed Feb 11 1930 Stella Crane

Registrar.

STATE
DEPARTMENT OF HEALTH, WELFARE
BUREAU OF VITAL STATISTICS

Registration District ..... Registration No. .....

FULL NAME ..... (If mother substitutes the word "stillborn" for name, write it here)

Sex of Child ..... Legitimate? ..... Date of birth ..... (Month) ..... (Day) ..... (Year)

What medicine was used to prevent infectious ophthalmia neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living .....

(b) Stillborn .....

FATHER		MOTHER
FULL NAME	FULL MAIDEN NAME	
Residence (Usual place of abode)		
If nonresident, give place and state		
Color or race	Age at last birthday	(Years)
Birthplace (City and State or country)		

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was (born alive) (stillborn) on the date above stated.

(Signature) .....

(Title or degree) .....

Address .....

Filed ..... 19 .....

(Registrar)

If in case of more than one child at birth, state number of birth ..... (Write "1" if first child, "2" if second child, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WHITE PLAINLY WITH INDELIBLE INK—THIS IS A LEGAL DOCUMENT
N. B.—In case of more than one child at birth, state number of birth ..... (Write "1" if first child, "2" if second child, etc.)

REC D MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69701

Registration District No. 13
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Valley
City of Cascade
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Hughes.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feby 11 - 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cascade, Idaho

PARENTS
10. NAME OF FATHER Rufus Hughes.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Zada Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas.

14. Informant Rufus Hughes
(Address) Cascade, Idaho

15. Filed Feby 11, 1930 Stella Carr
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19—, to —, 19—
that I last saw her alive on —, 19
and that death occurred, on the date stated above, at — m.
The CAUSE OF DEATH* was as follows: Stillborn - Hydrocephalus and spina bifida
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Roscoe C. Ward M.D.
2/11/30, 19 (Address) Cascade Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

JUL 1 9 1985

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

395 212-001-442

PLACE OF BIRTH

County of Ada

City of Boise

No. ..... St.

St Lukes

(If born in hospital or institution give name.)

REC'D APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 2 State File No. 179285

Prim. Registration District No. 1004 Local Registrar's No. 14

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child F | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth Feb (Month) 12 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth One (a) Born alive, and now living 0

Born alive but now dead 0 Stillborn One

FATHER	MOTHER
FULL NAME R. C. McCready	FULL MAIDEN NAME Mary Elizabeth Winkler
Residence (Usual place of abode) Boise	Residence (Usual place of abode) Boise
If nonresident, give place and State R5	If nonresident, give place and State R5
Color or race White Age at last Birthday 21 (Years)	Color or race White Age at last Birthday 19 (Years)
Birthplace Pittsburg Penn (City and State or Country)	Birthplace Oconto Neb (City and State or Country)
Occupation Lumberjack	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 4.59 on the date above stated.

(Signature) A B Borck

M.D.

(Physician or midwife)

Address Boise Idaho

Filed 3-17 1930 W. N. Rhodes

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Boech.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69408

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

2. FULL NAME Infant McCready

(a) Residence. No. 2310 Broadway St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb-12-1930

7. AGE: Years | Months | Days: 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: Robert Cole McCready
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oakdale Penn
12. MAIDEN NAME OF MOTHER: Mary Elizabeth Winkleman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nebraska

14. Informant: Robert C. McCready
(Address) RW #5, Boise Idaho

15. Filed 2-18, 1930 A. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 12 (Month) (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930, to, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Still born — Premature
Cause
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Eclampsia of
Pregnancy (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. B. Boech M. D.
Feb 15, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Feb-17 1930
20. Undertaker: Summers & Krebs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED APR 15 1930

PLACE OF BIRTH
County of Bear Lake
City of Paris
No. ..... St.
219 203 014 236
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 179329

Registration District No. 23 State File No.
Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Alice Barfuss
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Female
Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth
Legitimate? yes
Date of birth: Feb. 3 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 12 (a) Born alive and now living 9
Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Andrew Barfuss
Residence (Usual place of abode) Paris Idaho
If nonresident, give place and State
Color or race White Age at last Birthday 52 (Years)
Birthplace Switzerland (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Louise Stocker
Residence (Usual place of abode) Paris Idaho
If nonresident, give place and State
Color or race White Age at last Birthday 41 (Years)
Birthplace Switzerland (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / Stillborn} at 5:00 P.M. on the date above stated.

(Signature) Spencer H Rich
Physician
(Physician or midwife)
Address Paris Idaho

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed 4-18-1930 Mrs. J. P. Skinner
Registrar.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69061

PLACE OF DEATH

County of Bear Lake

City of Paris

Registration District No. 6-3

Primary Registration District No.

Local Registrar's No. 142

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Alice Barfuss

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Feb. 3 1930

7. AGE Years | Months | Days | If less than 1 day, Stillbirth hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Paris Idaho

PARENTS

10. NAME OF FATHER Andrew Barfuss

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Louise Stocker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Andrew Barfuss
(Address)

15. Filed Feb 5, 1930 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1930, to Feb. 3, 1930

that I last saw her alive on —, 19

and that death occurred, on the date stated above, at Strikemore

The CAUSE OF DEATH* was as follows:

Prolapse of Umbilical Cord

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Manual Delivery

(Signed) Spencer H. Price, M.D.

Feb. 3, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho | Date of Burial: Feb. 3 1930

20. Undertaker: Edwin T. Shepherd | Address: Paris Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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179329

JUL 29 1980

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia**, ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 849-127 03-168

County of Bannock APR 11 1930

City of Pocatello

No. St.

Poc. Gen. Hosp.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

W. Brothers

CERTIFICATE OF BIRTH S 179347

Registration District No. 28 State File No.

Prim. Registration District No. 216 Local Registrar's No. 9729

FULL NAME OF CHILD "Stillbirth" Hurst

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? — and Number in order of birth — (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Mar. 27 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 2

FATHER	MOTHER
FULL NAME Clarence Merlyn Hurst	FULL MAIDEN NAME Eva Marie Johnson
Residence (Usual place of abode) Black Foot	Residence (Usual place of abode) Black Foot
If non-resident, give place and State —	If non-resident, give place and State —
Color or race White Age at last Birthday 43 (?) (Years)	Color or race White Age at last Birthday 28 (Years)
Birthplace Kansas (City and State or County)	Birthplace Nebraska (City and State or County)
Occupation Bee Keeper	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 11:45 P. M. on the date above stated.

(Signature) W. W. Brothers

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Pocatello Ida.

Filed 4/1 1930 J. H. Young

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69778

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Gen. Hospital Poca. Idaho
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5792

2. FULL NAME Infant Hurst
(a) Residence. No. Blackfoot Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 28-1930

7. AGE Years | Months | Days | If LESS than 1 day, Still Born hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER C. M. Hurst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Eva Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant C. M. Hurst
(Address) Blackfoot Idaho

15. Filed 3/29, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 3-28, 1930, to 3-28, 1930 that I last saw he alive on Still born, 19 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion of mother
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) W. W. Brothers M. D.
3-28, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot Idaho — Date of Burial: March 28 1930

20. Undertaker: R. L. McFarl — Address: Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED APR 7 1930

PLACE OF BIRTH
County of Bonner
City of Priest River
No. ..... St.
231 222-009 419
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 179420

Registration District No. 76 State File No.
Prim. Registration District No. 2155 Local Registrar's No. 41

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? (To be answered only in event of plural births) | and | Number in order of birth | Legitimate? Yes | Date of birth Mar. 22 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 4
Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Luther Earl Starr	FULL MAIDEN NAME Myrtle Darrell
Residence (Usual place of abode) Priest River, Idaho	Residence (Usual place of abode) Priest River, Idaho
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 35 (Years)	Color or race White Age at last Birthday 35 (Years)
Birthplace Iowa (City and State or Country)	Birthplace Chicago Ill (City and State or Country)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 8:40 A. M. on the date above stated.

(Signature) P. S. Ross M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Sandpoint Idaho

Filed April 3 1930 Viola Allen Deputy Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69821

Registration District No. 78
Primary Registration District No. 2155
(No.) Local Registrar's No. 30

PLACE OF DEATH
County of Bonner
City of Kootenai

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Starr

(a) Residence. No. Kootenai Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 22, 1930

7. AGE: Years: still | Months: birth | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kootenai Idaho

PARENTS

10. NAME OF FATHER Luther E Starr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Myrtle Darrell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant L.E. Starr
(Address) Kootenai Ida

15. Filed March 24 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22, 1930, to Mar 22, 1930
that I last saw h— alive on —, 19
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Stillborn Cause unknown
Gestation; Duration P.M. yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) R J Ross M. D.
Mar. 24, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: Mar 24 1930

20. Undertaker: Trenbull Co — Address: Sandpoint

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED APR 11 1930 — STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS

PLACE OF BIRTH

County of Canyon

City of Caldwell

No. 445 702014

Caldwell Sanitarium

(If born in hospital give name.)

State File No. 179495

Prim. Registration District No. 2005 Local Registrar's No. 69

179495

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) 19 (Year)
Boy			Yes	4/2/30

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead Stillborn

FATHER		MOTHER	
FULL NAME	R. L. Dunagan	FULL MAIDEN NAME	Leva Stemper
Residence (Usual place of abode)	R. F. D. 1, Parma, Idaho	Residence (Usual place of abode)	R. F. D. 1, Parma, Idaho
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	21	Age at last Birthday (Years)	20
Birthplace (City and State or Country)	Idaho	Birthplace (City and State or Country)	Idaho
Occupation	Farming	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 7:30 A. M. on the date above stated.

(Signature) F. H. Cole

M. D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Caldwell, Idaho

Filed 4-4- 1930 - John S. Meyers Registrar.

[redacted]

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69850

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 9
Primary Registration District No. 2005
(No.)

Local Registrar's No. 34

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Boby Flanagan

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 4/2 30

7 AGE Years 0 Months 0 Days 0 If LESS than 1 day 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10 NAME OF FATHER R. H. Flanagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho

12 MAIDEN NAME OF MOTHER Cora Kemper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant R. H. Flanagan
(Address) Parma, Idaho, Rte. 1

15 Filed 4-2-, 1930. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 2, 1930, that I last saw h. alive on , 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Birth injury Very
Deformed instrument
Stillborn
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.
4/2, 1930 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Roswell Cemet. Date of Burial 4-3-1930

20. Undertaker Gathes and Friends. Address Parma - Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

PLACE OF BIRTH RECEIVED APR 4 1930

County of Elmore

City of Glenns Ferry

No. ..... St.

162 118 020 4114

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179532

Registration District No. 35 State File No. .....

Prim. Registration District No. 2021 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	March 8 – 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead None Stillborn 2

FATHER	MOTHER
FULL NAME Volney F. Johnson	FULL MAIDEN NAME Ethel Annie Madsen
Residence (Usual place of abode) Glenns Ferry Idaho	Residence (Usual place of abode) Ferry
If nonresident, give place and State —	If nonresident, give place and State —
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday ..... (Years)
Birthplace Utah (City and State or Country)	Birthplace Utah (City and State or Country)
Occupation Boilermaker O.S.L.R.R.	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 1 P. M. on the date above stated.

(Signature) Dr. J. W. Davis

Physician

(Physician or midwife)

Address Glenns Ferry Idaho

Filed 3 – 17 1930 Mrs Mary Sullivan

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69894

- PLACE OF DEATH

County of Gooding

City of Glenns Ferry

Registration District No. 35

Primary Registration District No. 2021

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

note

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): March 8 - 1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Glennis Ferry Ida

PARENTS

10. NAME OF FATHER: Volmer F. Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel Annie Madsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Mrs Volmer Johnson
(Address): Glennis Ferry Ida

15. Filed 3-17, 1930 Mrs Mary Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. W. Davis M. D.

3-17, 1930 (Address) Glennis Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glenns Ferry Ida | Date of Burial: 3-8 1930

20. Undertaker: Volmer Johnson | Address: Glenns Ferry Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Franklin RECEIVED APR 9 1930

City of Mink Creek Ida

No. ..... St. .....

251-109 021.157

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 179570

Registration District No. 27 State File No. 179570

Prim. Registration District No. 2119 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
male				yes	Mar 9 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? ~~no~~

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead ..... Stillborn 1

FATHER		MOTHER	
FULL NAME	Melvin Seamons	FULL MAIDEN NAME	Lora Jepson
Residence (Usual place of abode)	Mink Creek, Ida	Residence (Usual place of abode)	Mink Creek, Ida
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	26	Age at last Birthday (Years)	24
Birthplace (City and State or County)	Cleveland Ida	Birthplace (City and State or County)	Mink Creek, Ida
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was [~~Born Alive~~ / Stillborn] at 1:30 A. M. on the date above stated.

(Signature) Eugene Worley
Physician
(Physician or midwife)

Address Preston Ida

Filed Mar 11 1930 A. R. Cutler
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

PLACE OF DEATH

County of Franklin

City of Mink Creek Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69906

Local Registrar's No. .....

2. FULL NAME Stillborn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Mar 9, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stillborn

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mink Creek Ida

PARENTS

10. NAME OF FATHER: Melvin Seamons

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cleveland Ida

12. MAIDEN NAME OF MOTHER: Leora Jeppson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mink Creek Ida

14. Informant: Melvin Seamons

(Address): Mink Creek, Ida

15. Filed Mar 11, 1930 — G. R. Cutler, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9, 1930, to Mar 9, 1930 that I last saw him alive on Mar 9, 1930 and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows: Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Instrumental Delivery

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene [illegible], M. D.

Mar 9, 1930 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mink Creek, Ida — Date of Burial: Mar. 10 1930

20. Undertaker — Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179674

PLACE OF BIRTH
County of Jefferson
City of Rigby
No. ..... St.
266-222-026-365
(If born in hospital or institution give name.)

Registration District No. 98 State File No.
Prim. Registration District No. 176 Local Registrar's No. 6

FULL NAME OF CHILD Not Named (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				yes	Feb 22 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Thomas Tyman Bowles	FULL MAIDEN NAME Martha Leone Lovell
Residence (Usual place of abode) Rexburg Ida	Residence (Usual place of abode) Rexburg Ida
If nonresident, give place and State	If nonresident, give place and State
Color or race Wht. Age at last Birthday 20 (Years)	Color or race Wht. Age at last Birthday 18 (Years)
Birthplace Nephi Utah (City and State or Country)	Birthplace Rexburg Ida (City and State or Country)
Occupation Farming	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 7:10 P. M. on the date above stated.

(Signature) H. R. Abbott M.D.
(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Rexburg Idaho.

Filed MAR 1 1930 19.....

C. H. GAVIN, M.D.
Registrar.

863-212-003-955

PLACE OF BIRTH

RECEIVED APR 11 1930

County of Bannock

City of Pocatello

No. St. Anthony St.

Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

179760

Registration District No. 28 State File No.

Prim. Registration District No. 2161 Local Registrar's No. 9686

FULL NAME OF CHILD (Stillbirth) Donna Lee Holcomb

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				yes	2-12 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn

FATHER		MOTHER	
FULL NAME	Willis C. Holcomb	FULL MAIDEN NAME	Leah Margaret Reese
Residence (Usual place of abode)	616 North 18th	Residence (Usual place of abode)	816 North 18th
If non-resident, give place and State		If non-resident, give place and State	
Color or race	W	Color or race	W
Age at last Birthday	21 (Years)	Age at last Birthday	20 (Years)
Birthplace (City and State or County)	St. Anthony, Idaho	Birthplace (City and State or County)	Goldberg, Idaho
Occupation	Candy maker	Occupation	House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 6 45 M. on the date above stated.

(Signature) [illegible]

(Physician or ~~midwife~~)

Address Pocatello Idaho

Filed 4/1 1930 [illegible]

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 19437

Local Registrar's No. 57762

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 214

(No. St Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Holcomb

(a) Residence. No. 816 North 12th St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 12, 1930.

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborne

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS

10. NAME OF FATHER: W. C. Holcomb

11. BIRTHPLACE OF FATHER (city or town) (State or Country): St Anthony Idaho

12. MAIDEN NAME OF MOTHER: Leah Reese

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boldburg Idaho

14. Informant: W. C. Holcomb
(Address): 816 No 12th Ave

15. Filed 2/13, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 12th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still birth
Breach delivery —
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Manipulated Cord —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Miller, M. D.

2/13, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery
Date of Burial: Feb 13, 1930

20. Undertaker: Hall Mortuary
Address: Pa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED APR 4 1930

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Minidoka

City of Rupert

No. 863-182-034-693

Jones Maternity Home
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
179841

Registration District No. 19 State File No.

Prim. Registration District No. 2015 Local Registrar's No. 55

FULL NAME OF CHILD Still born
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
boy			Yes	May 22 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Victor Hall	FULL MAIDEN NAME	Ellen C. Willison
Residence (Usual place of abode)	Rupert	Residence (Usual place of abode)	Rupert
If nonresident, give place and State	Ohio	If nonresident, give place and State	Ohio
Color or race	White	Color or race	White
Age at last Birthday	34 (Years)	Age at last Birthday	38 (Years)
Birthplace (City and State or Country)	Mont	Birthplace (City and State or Country)	Ontario
Occupation	Farmer	Occupation	House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 4 P M. on the date above stated.

(Signature) Joyce A. Kenagy
(Physician or midwife)

Address Rupert

Filed 3-31 1930 Ella E. Lane
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20013

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME Still Born Male

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, Still hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Victor R. Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Montana
12. MAIDEN NAME OF MOTHER: Ellen Willison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Victor R Hall
(Address): Rupert Idaho R. 3

15. Filed 6-10, 1930 Elbert Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Asphyxia Neonatorum
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Fayne H. Kenagy, M. D.
5-13, 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetery — Date of Burial: Mar 23 1930
20. Undertaker: W. O. Gordanier — Address: Rupert Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

219-122-035-619

PLACE OF BIRTH RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce

City of Lewiston

No. ..... St.

Registration District No. 96 File No. 179844

Hospital Whites

Primary Registration District No. 1009 Registered No. .....

FULL NAME OF CHILD Paul Elwood Kartemeier
(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male			1	yes	Feb 22 1930

What bactericidal solution was used in eyes? 20 % argyrol

Number of child of this mother, including present birth 1. Number of children of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	Henry Albert Kartemeier	FULL MAIDEN NAME	Grace Swinson Waite
RESIDENCE	Kendrick Ida	RESIDENCE	Kendrick, Ida
COLOR	White	COLOR	white
AGE AT LAST BIRTHDAY (Years)	33	AGE AT LAST BIRTHDAY (Years)	29
BIRTHPLACE	Iowa	BIRTHPLACE	Washington
OCCUPATION	Labor	OCCUPATION	House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ..... (Born alive or stillborn) at 12 30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. L. White
(Physician or midwife)

Address Lew. Ida

Filed Jan 1 1930 Susan E. Brown
Registrar.

Give names added from a supplemental report.

..... 192....

..... Registrar.

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 8593

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1029
(No. Mobile Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Kontemeier

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Still Born

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 - 1930

7. AGE Years Months Days Still Born
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER H A. Kontemeier
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Grace Waite
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant H A. Kontemeier
(Address) Kendrick Ida

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Still Born 2/22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-22, 1930, to 2-22, 1930
that I last saw h ~~alive on~~, 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Premature birth - 7 mo.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Unknown except mother had flu 2 weeks before
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? History -
(Signed) E. L. White, M. D.
2-24, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida — Date of Burial 2/22 1930
20. Undertaker Vassar Mortuary — Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

179844 2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; **(a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

255-64-062-5-13

PLACE OF BIRTH

County of Twin Falls

City of Kimberly

No. ..... St.

(If born in hospital or institution give name.)

REC'D APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179975

Stillborn

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD Royal Glenn Burson Jr.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
Boy				yes	2	14	1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1st (a) Born alive and now living .....

Born alive but now dead one Stillborn .....

FATHER	MOTHER
FULL NAME Royal Glenn Burson	FULL MAIDEN NAME Edna Elizabeth Vallise
Residence (Usual place of abode) Deceased	Residence (Usual place of abode) Kimberly
If nonresident, give place and State	If nonresident, give place and State .....
Color or race ..... Age at last Birthday 31 (Years)	Color or race white Age at last Birthday 20
Birthplace Earlham Ia (City and State or Country)	Birthplace Colorado Springs Colo (City and State or Country)
Occupation	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 1:30 P.M. on the date above stated.

(Signature) C. D. Werner

(Physician ~~or midwife~~)

Address Twin Falls Ida

Filed 3. 3. 1930 Elizabeth J. Smutt
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 3 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho APR 21 1930

179975

Mrs. R.G. Beeson
Kimberly

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD [illegible]

PLACE OF BIRTH** Kimberly DATE OF BIRTH Feb. 14, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 1
2. Number born alive and now living 0
3. Born alive but now dead
4. Number of children stillborn 1

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
[illegible] (deceased)	Edna Elizabeth [illegible]
(Full name)	(Full Maiden name)
	[illegible]
(Residence)	(Residence)
Age at last birthday 21	Age at last birthday 21
Earlham, Iowa.	[illegible]
(Birthplace)	(Birthplace)
(Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey

C.K. Macey
Special Agent, Bureau of the Census.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 60691

PLACE OF DEATH
County of Twin Falls
City of Kimberly

Registration District No.
Primary Registration District No.
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Royal Glenn Beeson
(a) Residence. No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14 1930

7. AGE: Years 5 | Months 2 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kimberly Ida

PARENTS
10. NAME OF FATHER Royal Beeson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Edna Paline
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colo

14. Informant Edna Paline
(Address) Kimberly

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Feb. 14, 1930, to , 19
that I last saw h~~alive on~~ , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH was as follows: Still born at 9 mo.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. O. Weaver, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Feb 15 1930
20. Undertaker: F. J. Grossnickle — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, **Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; **(a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

287-125-044-134

PLACE OF BIRTH

County of Washington

City of Weiser

No. ..... St.

(If born in hospital or institution give name.)

MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 180004**

Registration District No. 76 State File No. .....

Prim. Registration District No. 2112 Local Registrar's No. 2

FULL NAME OF CHILD Joseph Albert Shirk
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate	Date of birth (Month) (Day) (Year)
boy				yes	Feb 25 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Robert S Shirk	FULL MAIDEN NAME Matter M Alderson
Residence (Usual place of abode) Weiser	Residence (Usual place of abode) Weiser
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 45 (Years)	Color or race white Age at last Birthday 35 (Years)
Birthplace Iowa (City and State or Country)	Birthplace Wash (City and State or Country)
Occupation farmer	Occupation house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 3a M. on the date above stated.

(Signature) F A Schmidt M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Weiser Idaho.

Filed March 1 1930 M. R. Hamilton
Registrar.

Don't know cause of still birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

JUL 0 6 2017

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

1 18004

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20016

Local Registrar's No. 13

PLACE OF DEATH

County of Washington

City of Weiser

Registration District No. 16

Primary Registration District No. 101C

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Albert Shirts

(a) Residence. No. Weiser Ida Route #2 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: wht

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Stillborn

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Weiser Idaho

PARENTS

10. NAME OF FATHER: R. B. Shirts

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mattie Alderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington

14. Informant: R. B. Shirts

(Address): Weiser Ida R7B #2

15. Filed Mar 4, 1930 W. A. Kauffman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to Feb 24, 1930 that I last saw he alive on , 19 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born
Cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Schmidt, M. D.

2-24, 1930 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weiser Creek | Date of Burial: 2-25 1930

20. Undertaker: L. G. Northam | Address: Weiser Ida

JUL 0 6 2017

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 7 1930

County of Ada

City of Boise, Idaho

No. ..... St.

St. Alphonsus Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180132

Registration District No. 2 State File No.

Prim. Registration District No. 1804 Local Registrar's No. 183

FULL NAME OF CHILD Stillbirth,
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female	X (To be answered only in event of plural birth)		1st	yes	3-12-30 19....

What prophylactic was used to prevent Ophthalmia Neonatorum? 0

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead 0 Stillborn

FATHER	MOTHER
FULL NAME Wm. Oscar Bragstad,	FULL MAIDEN NAME Jessie Lowe
Residence (Usual place of abode) Boise, Idaho	Residence (Usual place of abode) Boise, Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 40 (Years)	Color or race White Age at last Birthday 35 (Years)
Birthplace S. Dakota, (City and State or County)	Birthplace Rippey, Iowa, (City and State or County)
Occupation Plasterer	Occupation Housework.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at ..... M. on the date above stated.

(Signature) Geo Collister

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 5-7 1930 W. H. Rhodes
Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69747

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 76
(No. St Alphonsus Hospital,
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Bragstad
(a) Residence. No. 516 N 12 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 12, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER William O. Bragstad
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota
12. MAIDEN NAME OF MOTHER Jessie Alice Fowl
13. BIRTHPLACE OF MOTHER (city or town) (State or County) South Dakota

14. Informant William O. Bragstad
(Address) 516 N 12 St Boise Idaho

15. Filed 3-13, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 12 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1930 to Mar. 12, 1930
that I last saw her alive on Mar 12, 1930
and that death occurred, on the date stated above, at 11:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo Calvert M. D.
3/13, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: Mar. 12, 1930
20. Undertaker: Summers & Kreft | Address: Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 5 1930

PLACE OF BIRTH
County of Bannock
City of McCammon
No. ..... St.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 84 State File No. 180229
Prim. Registration District No. 2161 Local Registrar's No. 760

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male
Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth
Legitimate? Yes
Date of birth: Feb. (Month) 8 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead ..... Stillborn This one

FATHER	MOTHER
FULL NAME: King George Hillman	FULL MAIDEN NAME: Raymona Winifred Pompson
Residence (Usual place of abode): McCammon	Residence (Usual place of abode): McCammon
If nonresident, give place and State:	If nonresident, give place and State:
Color or race: White Age at last Birthday: 27 (Years)	Color or race: White Age at last Birthday: 21 (Years)
Birthplace: Downey Idaho (City and State or Country)	Birthplace: Downey Idaho (City and State or Country)
Occupation: Farmer	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 7 a. M. on the date above stated.

(Signature) C. A. Rich M.D.
(Physician or midwife)

Address Lava Hot Springs Ida.

Filed Apr. 15 1930 Mrs. G. G. Fitz
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

City of _____

No. _____ B. _____

Registration District No. _____ Sub-District No. _____

(If born in hospital, give name of institution)

Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

(If children, enumerate the seven "Multiples" for name of child)

Sex of Child	Twins or others? (To be answered only in case of plural births)	Length. Weight	Date of birth (Month)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

	FATHER	MOTHER
FULL NAME		
MAIDEN NAME		

Residence (Usual place of abode) _____ Residence (Usual place of abode) _____

If nonresident, give place and State _____ If nonresident, give place and State _____

(Year) _____ Birthplace (City and State or Country) _____

(Occupation) _____ (Occupation) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(Please write)

I hereby certify that I attended the birth of this child, who was born alive at _____ M. on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Date _____, 19_____

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2 copies

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70112

PLACE OF DEATH
County of Bannock
City of Mc Cammon
Registration District No. 84
Primary Registration District No. 2161
Local Registrar's No. 178
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stilburth
(a) Residence. No. Mc Cammon Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None
6. DATE OF BIRTH (month, day and year) Feb 8, 1930.
7. AGE Years Months Days If LESS than 1 day, hrs. or 8 min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None
9. BIRTHPLACE (city or town) Mc Cammon (State or country) Idaho

PARENTS
10. NAME OF FATHER King George Hillman
11. BIRTHPLACE OF FATHER (city or town) Downey (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Raymona Winifred Thompson
13. BIRTHPLACE OF MOTHER (city or town) Downey (State or Country) Idaho

14. Informant C A Rich M.D. copy from Birth certificate
(Address) Lava Hot Springs
15. Filed Apr 15, 1930. Mel G. G Fet Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 8 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from At birth 19 , to Feb 8, 1930
that I last saw him alive on Stilburth 2-8, 1930.
and that death occurred, on the date stated above, at 7 Am m.
The CAUSE OF DEATH* was as follows:
Injury during birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Disproportion in outlet of Mother (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. A. Rich, M. D.
2-8, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19
20. Undertaker | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

PLACE OF BIRTH
County of Bingham
City of Blackfoot
No. R D # 2 St.
(If born in hospital or institution give name.)

Registration District No. 121 State File No. 1[illegible]365
Prim. Registration District No. 2194 Local Registrar's No. 99

FULL NAME OF CHILD Stillborn Murdock
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child ~~Male~~ Female | Twin / Triplet / or other? (To be answered only in event of plural births) | and | Number in order of birth | Legitimate? Yes | Date of birth April 1 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 9 (a) Born alive and now living 7
Born alive but now dead 1 Stillborn This one

FATHER	MOTHER
FULL NAME Leo D. Murdock	FULL MAIDEN NAME Francis Rosetta Dance
Residence (Usual place of abode) Blackfoot	Residence (Usual place of abode) Blackfoot
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday 37 (Years)
Birthplace Utah (City and State or Country)	Birthplace Utah (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / ~~Stillborn~~ / Stillborn} at 3:a.m. M. on the date above stated.

(Signature) C W Beck MD
(Physician or Midwife)
Address Blackfoot Idaho
Filed May 3 1930 Mrs Valeene Calvin
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70143

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 7194
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 49

2. FULL NAME Stillborn Murdock.

(a) Residence. No. Blackfoot R.F.D. #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years ✓ Months ✓ Days ✓ If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Blackfoot Idaho

PARENTS
10. NAME OF FATHER: Leo D Murdock
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Marysvale Utah
12. MAIDEN NAME OF MOTHER: Frances Dance
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wilson Utah

14. Informant: Leo D Murdock
(Address): Blackfoot RR#2

15. Filed April 1, 1930 Mrs Helen E Stone
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~March~~ April (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/1, 1930
that I last saw her alive on Stillborn, 19
and that death occurred, on the date stated above, at 3:00 a.m.
The CAUSE OF DEATH* was as follows:
Placenta Previa
Complete Central
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
4/1, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Rummel — Date of Burial: April 1930

20. Undertaker: E J Peck — Address: Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED APR 25 1930

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. ..... St. .....

L.D.S. Hosp.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180311

Registration District No. 73 State File No. .....

Prim. Registration District No. 2-17-1 Local Registrar's No. 101

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	March 12 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living .....

Born alive but now dead 1 Stillborn .....

FATHER	MOTHER
FULL NAME Herbert C. Meppen	FULL MAIDEN NAME Hilda Theodora Tornetta
Residence (Usual place of abode) Shelley, Idaho	Residence (Usual place of abode) Shelley, Idaho
If non-resident, give place and State	If non-resident, give place and State .....
Color or race white Age at last Birthday 29 (Years)	Color or race white Age at last Birthday 25 (Years)
Birthplace Council Bluffs, Iowa (City and State or County)	Birthplace Council Bluffs Iowa (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / ~~Stillborn~~ } at 3 10 A. M. on the date above stated.

(Signature) [illegible] M.D.

(Physician or midwife)

Address Idaho Falls, Idaho

Filed Mar 21 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70168

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 1210
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1-1

204

2. FULL NAME Infant Meppen.
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 12-1930

7. AGE: Years: no; Months: no; Days: no. If LESS than 1 day, no hrs. or no min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Ida.

PARENTS

10. NAME OF FATHER Herbert Meppen.
11. BIRTHPLACE OF FATHER (city or town) Council Bluffs Ia.
(State or Country)
12. MAIDEN NAME OF MOTHER Hilda Forrester.
13. BIRTHPLACE OF MOTHER (city or town) Council Bluffs
(State or Country) Ia.

14. Informant Herbert Meppen.
(Address) Shelley Idaho.

15. Filed Mar 13, 1930 J. Cousins
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12, 1930, to Mar 12, 1930
That I last saw him alive on Mar 12, 1930
and that death occurred, on the date stated above, at 3 40 A. m.
The CAUSE OF DEATH* was as follows:
Premature birth
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cause Unknown
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? ✓
What test confirmed diagnosis? .....
(Signed) ..... M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 3/13 1930
20. Undertaker: V. F. M Hav. Address: Idaho Falls Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

253-129-014-243

PLACE OF BIRTH

MAY 10 1930

County of Canyon

City of Nampa

No. ~~533 14th Ave So.~~ St.

R.F.D. #1

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 180347

Registration District No. 7 State File No.

Prim. Registration District No. 2016 Local Registrar's No. 77

FULL NAME OF CHILD Aubrey Paul Becker.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth

Legitimate? Yes

Date of birth: 4 (Month) - 29 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 10%

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead none Stillborn Two.

FATHER	MOTHER
FULL NAME A. Peter Becker	FULL MAIDEN NAME Fannie Laurene Bucher.
Residence (Usual place of abode) Nampa Rt.	Residence (Usual place of abode) Nampa Rt.
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 35 (Years)	Color or race White Age at last Birthday 34 (Years)
Birthplace Germany (City and State or Country)	Birthplace Astoria Ill. (City and State or Country)
Occupation Minister of the Gospel	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / Stillborn at 4:10 P. M. on the date above stated.

(Signature) L. C. Horton M.D.

(Physician or midwife)

Address Nampa Idaho.

Filed 5/2 1930 Bertha Conway Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70178

PLACE OF DEATH

County of Canyon

City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 2006 Local Registrar's No. 52

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

304

2. FULL NAME Aubrey Paul Becker

(a) Residence. No. Lone Star road St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29 - 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER A. P. Becker

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Fannie L. Baker

13. BIRTHPLACE OF MOTHER (city or town) Astoria
(State or County) Illinois

14. Informant A. P. Becker
(Address) Nampa, Idaho

15. Filed 4-30 19 30 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 - 29 19 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
4-29 19 30 to 19
that I last saw him alive on
and that death occurred, on the date stated above, at 4:10 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] M. D.
4-30 19 30 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal Rotherlawn - Nampa Date of Burial 4-30 1930

20. Undertaker [illegible] D. Talley Address Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

18 0347 N

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Franklin

City of Preston Ida

No. ..... St.

(If born in hospital or institution give name.)

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 180406

Registration District No. 27 State File No. .....

Primr Registration District No. 2119 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth April 29 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 8 (a) Born alive and now living 7

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Jacob Alonzo Eaton	FULL MAIDEN NAME Estella Geddes
Residence (Usual place of abode) Preston Ida	Residence (Usual place of abode) Preston Ida
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 45 (Years)	Color or race White Age at last Birthday 45 (Years)
Birthplace Preston Ida (City and State or County)	Birthplace Preston Ida (City and State or County)
Occupation Sheriff	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Premature~~ / Stillborn } at 8:00 P. M. on the date above stated.

(Signature) Clifford Morley

Physician

(Physician or midwife)

Address Preston Idaho

Filed 4-29 1930 A. E. Miller

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

[illegible]

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70211

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2014

2. FULL NAME Stillborn Paton Baby

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29, 1930

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston, Idaho

PARENTS

10. NAME OF FATHER Jacob Alonzo Paton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston, Idaho

12. MAIDEN NAME OF MOTHER Estella Geddes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Preston, Idaho

14. Informant J. A. Paton
(Address) Preston, Idaho

15. Filed , 19 C. R. Wells Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Worley, M. D.

April 30 1930 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

793-138-025-793

PLACE OF BIRTH
RECEIVED APR 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180524

County of Idaho

City of Grangeville

No. ..... St. Registration District No. ..... State File No. .....

Hospital ..... Primary Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD Edward Walter Gillett
(Certificate of no value without full name of child)

Sex of Child: male

Twin / Triplet / or other? } and { Number in order of birth
(To be answered only in event of plural births)

Legitimate? yes

Date of birth: 3 - 28 - 1930
(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth: 3

Number of child of this mother now living, including present birth: 2

FATHER		MOTHER	
FULL NAME	Roy Gillett	FULL MAIDEN NAME	Caroline Effie Gillette
RESIDENCE	Grangeville, Idaho	RESIDENCE	Grangeville, Idaho
COLOR	white	COLOR	white
AGE AT LAST BIRTHDAY	34 (Years)	AGE AT LAST BIRTHDAY	37 (Years)
BIRTHPLACE	Nebraska	BIRTHPLACE	Oregon
OCCUPATION	Farmer	OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 6 15 p. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. P. Weber

(Physician or, ~~midwife~~)

Address Grangeville, Ida

Give names added from a supplemental report.

....., 192....

Registrar.

Filed April 28 1930 Bessie M. Lipper State Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76256

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
(No. Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Baby Gillitt

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Still-born

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-28-30

7. AGE: Years: Still-born; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville

PARENTS
10. NAME OF FATHER Roy Gillitt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Carrie Gillitte
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Roy Gillitt
(Address) B. Chipman Registrar

15. Filed 5-3, 1930

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to 3-28, 1930
that I last saw b~~aby~~ alive on 3-28, 1930
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows: Hard labor caused by previous operation to mother causing death to baby. (duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. Weber M. D.
3-29, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville — Date of Burial: 3-30 1930

20. Undertaker: Vasdar — Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. **Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED APR 21 1930

PLACE OF BIRTH

County of Jerome

City of Jerome

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180533

Registration District No. 18 State File No. .....

Primary Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD not named - Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin, Triplet or other?	Number in order of birth	Legitimate?	Date of birth
Boy	—	—	Yes	Feb 25 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead one Stillborn one

	FATHER	MOTHER
FULL NAME	Walter M. Olds	FULL MAIDEN NAME Emma L. White
Residence (Usual place of abode)	Jerome Ida	Residence (Usual place of abode) Jerome Ida
If non-resident, give place and State	—	If non-resident, give place and State —
Color or race	White	Color or race White
Age at last Birthday	42 (Years)	Age at last Birthday 42 (Years)
Birthplace (City and State or County)	Neb	Birthplace West Va (City and State or County)
Occupation	Farmer	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 7 a M. on the date above stated.

Labor at 6½ mo.

(Signature) Paul Price
Physician
(Physician or midwife)

Address Jerome Ida

Filed 4/3 1930 Chas. F. Geller Jr. Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Cause Hepatic colic

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 26 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho MAY 20 1930

180533

Mrs. W. M. Otis
Jerome

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD No Name Premature Birth Stillborn

PLACE OF BIRTH** **Jerome** DATE OF BIRTH **Feb. 25, 1930** SEX OF CHILD **Male**

1. Number of children born to this mother, including present birth _____
2. Number born alive and now living _____
3. Born alive but now dead _____
4. ~~Number of~~ children stillborn _____

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
[illegible] (Full name)	[illegible] (Full Maiden name)
[illegible] (Residence)	_____ (Residence)
Age at last birthday _____	Age at last birthday _____
_____ (Birthplace)	_____ (Birthplace)
_____ (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey

C.K. Macey
Special Agent, Bureau of the Census.

743-206-030-743

PLACE OF BIRTH

RECEIVED APR 17 1930

Form V. S. No. 11-C—Rev. 6-3-17

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Lemhi

City of Salmon

Registration District No. 41

File No. 180641

No. ..... St.

Primary Registration District No. 2116

Registered No. .....

Hospital Rose

FULL NAME OF CHILD Putney

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of Birth (Month) (Day) (Year)
Female				No.	4-6-30

FATHER		MOTHER	
FULL NAME	Byron Radliff	FULL MAIDEN NAME	Nellie Putney
RESIDENCE	Butler, Ida	RESIDENCE	Montana
COLOR	White	COLOR	White
AGE AT LAST BIRTHDAY	..... (Years)	AGE AT LAST BIRTHDAY	16 (Years)
BIRTHPLACE	Idaho	BIRTHPLACE	Montana
OCCUPATION	Rancher	OCCUPATION	Housewife

Number of child of this mother, including present birth: One

Number of children of this mother now living, including present birth: One

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born (Born alive or stillborn) at 8:30 P. M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. B. Walton, MD

(Physician or midwife)

Given names added from a supplemental report.

..... 19.....

..... Registrar

Address Salmon, Idaho

Filed April 10 1930 Chas Bellamy Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 17 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 70292

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information. Rose Hospital

Registration District No. 41

Primary Registration District No. 2116

2. FULL NAME Pitney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 4 — 6 1930 (Month) (Day) (Year)

7. AGE: Still born. ....Yrs....Mos....ds.

IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION ✓

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Byron Radlitz

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Nellie Pitney

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma M. Pitney

(Address) Leadore, Idaho

15. Filed April 10 1930 Clio Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 — 6 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,

that I last saw h....alive on ....191....,

and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows: Still born - Footterm. Trauma in delivery of breech presentation.

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) .....

....(Duration) ....Yrs. ....mos. ....ds.

4/7 1930 (Signed) C. J. Stratton M. D.

(Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?.....

Former or usual residence Lemhi, Idaho

19. PLACE OF BURIAL OR REMOVAL Salmon, Ida. DATE OF BURIAL 4 7 1930

20. UNDERTAKER J. H. Rose ADDRESS Salmon, Ida

SYMS - YORK CO., PTRS. & BOKS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18641 +

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Minidoka

City of Rupert

No. ..... St.

(If born in hospital or institution give name.)

MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 180670

Registration District No. 19 State File No. .....

Prim. Registration District No. 2015 Local Registrar's No. 56

FULL NAME OF CHILD "Stillbirth"

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	3 18 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth One(s) Born alive and now living 0

Born alive but now dead None Stillborn One

FATHER	MOTHER
FULL NAME Worley D. Head	FULL MAIDEN NAME Viola M. Fangio
Residence (Usual place of abode) Rupert, Idaho	Residence (Usual place of abode) Rupert Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 29 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Byers Ferry Va (City and State or County)	Birthplace Dublin Va (City and State or County)
Occupation Sheep Raising	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / Stillborn} at 11:30 M. on the date above stated.

(Signature) Lelum Fuqua, M.D.

(Physician or midwife)

Address Rupert, Idaho

Filed 5-5-1930 E. E. Lemmon

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72858

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2012
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

2. FULL NAME Still Born

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, Still Born hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rupert Idaho

PARENTS
10. NAME OF FATHER: Wm. N. Head
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Vadot Ennis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: W. N. Head
(Address): Rupert Idaho

15. Filed Nov. 6, 1930 R. E. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18, 1930, to Mar 18, 1930
that I last saw h. alive on Still born, 19
and that death occurred, on the date stated above, at 11 3/4 A m.
The CAUSE OF DEATH* was as follows:
Fusion on umbilical cord. (Cord wrapped around child neck twice & fusion on some cut off circulation. (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Leland Ingersoll, M. D.
, 19 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetery | Date of Burial: Mar 19 1930
20. Undertaker: W. G. Goodenough | Address: Rupert

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH: County of Fremont
City of Driggs
Street ..... No. .....

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 180772

Registration District No. 77 Mother's File No. .....

(If born in hospital or institution give name.)

Prim. Registration District No. 2176 Local Registrar's No. 33

FULL NAME OF CHILD: Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female			Yes	4 – 3 – 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 7 (a) Born alive and now living 3

Born alive but now dead 3 Stillborn 1

FATHER	MOTHER
FULL NAME: O. F. Murdock	FULL MAIDEN NAME: Jennie Harriman
Residence (Usual place of abode): Driggs	Residence (Usual place of abode): Driggs
If non-resident, give place and State:	If non-resident, give place and State:
Color or race: W. Age at last Birthday: 41 (Years)	Color or race: W Age at last Birthday: 38 (Years)
Birthplace: Cornish Tom, Utah (City and State or County)	Birthplace: Hemming Tom Utah (City and State or County)
Occupation: Rancher	Occupation: H W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 8:30 P. M. on the date above stated.

(Signature) L. G. Parkinson
(Physician ~~or midwife~~)

Address Driggs Idaho

Filed 5-3-1930 Martha Marker
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[redacted]

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76328

PLACE OF DEATH
County of Teton
City of Driggs R.D.2.

Registration District No. 77
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

206

2. FULL NAME Stillbirth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Driggs, R.D. 2
(State or country) Idaho

PARENTS

10. NAME OF FATHER O. F. Murdock
11. BIRTHPLACE OF FATHER (city or town) Ephraim
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Zuma Harriman
13. BIRTHPLACE OF MOTHER (city or town) Hunnington
(State or Country) Utah

14. Informant O. F. Murdock
(Address) Driggs, R.D. 2, Idaho

15. Filed 5-2-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 — 3 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
—, 19..., to —, 19...
that I last saw h— alive on —, 19...
and that death occurred, on the date stated above, at —m.
The CAUSE OF DEATH* was as follows:

Premature (Immature)

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. Parkinson, M. D.
....., 19... (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bates, Idaho
Date of Burial: 4-4-1930

20. Undertaker —
Address —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. **If the information cannot be secured, it should be plainly stated unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 5 1930

PLACE OF BIRTH

County of Teton

City of Victor

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 180773

~~Registration District No. 77~~ ~~State File No.~~

Prim. Registration District No. 2176 Local Registrar's No. 31

FULL NAME OF CHILD Stillman

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				+	4 – 5 – 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Geo. F. Shatton	FULL MAIDEN NAME Medric Hatch
Residence (Usual place of abode) Victor	Residence (Usual place of abode) Victor
If non-resident, give place and State	If non-resident, give place and State .....
Color or race W Age at last Birthday 23 (Years)	Color or race W Age at last Birthday 22 (Years)
Birthplace Logan, Utah (City and State or County)	Birthplace Victor, Idaho (City and State or County)
Occupation Farmer	Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } **at** 9:00 P. M. **on the date above stated.**

(Signature) G. G. Parkinson

(Physician ~~or midwife~~)

Address ~~G. J. Parkinson~~ Driggs Ida

Filed 5-2-1930 Martha Marker
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

PLACE OF BIRTH

County of .....

City of .....

Ward .....

(If home or hospital, or institution give name.) Prim. Registration District No. ..... Local Registrar's No. .....

Registration District No. ..... Serial No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	Number in order of birth	Legitimate?	Date of birth ..... 19 (Month) (Day) (Year)
		(To be answered only in case of plural births)		

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... stillborn .....

	FATHER		MOTHER
FULL NAME		FULL MAIDEN NAME	
Residence (Usual place of abode)		Residence (Usual place of abode)	
If non-resident, give place and State		If non-resident, give place and State	
Color or race	Age at last Birthday ..... (Years)	Color or race	Age at last Birthday ..... (Years)
Birthplace (City and State or Country)		Birthplace (City and State or Country)	
Occupation		Occupation	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive / stillborn on the date above stated. M.D.

(Signature) .....

(Physician or midwife)

Address .....

Dated ..... 19 .....

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70327

PLACE OF DEATH
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Stillbirth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Victor, Idaho

PARENTS

10. NAME OF FATHER: Geo F Shatton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Logan Utah
12. MAIDEN NAME OF MOTHER: Madric Hurtik
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Victor Idaho

14. Informant: Geo F. Shatton
(Address): Victor, Idaho

15. Filed 5-2-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 — 5 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
—, 19..., to —, 19...
that I last saw h— alive on —, 19...
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Unknown (Macerated)

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. G. Markinson, M. D.
....., 19... (Address) Driggs Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Victor, Idaho — Date of Burial: 4-6-1930

20. Undertaker — Address —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

314-267042844

PLACE OF BIRTH

RECEIVED MAY 7 1930

County of Twin Falls

City of Buhl

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S180821

Registration District No. 39 State File No.

Prim. Registration District No. 2687 Local Registrar's No.

FULL NAME OF CHILD Mary Elizabeth Cammack

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate	Date of birth (Month) (Day) (Year)
F			yes	4 – 7 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME Francis Cammack	FULL MAIDEN NAME Dorothea Hudson
Residence (Usual place of abode) Buhl	Residence (Usual place of abode) Buhl
If nonresident, give place and State	If nonresident, give place and State
Color or race wh Age at last Birthday 23 (Years)	Color or race wh Age at last Birthday 19 (Years)
Birthplace Colo (City and State or Country)	Birthplace Ida (City and State or Country)
Occupation Laborer	Occupation HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 4 55 9 M. on the date above stated.

(Signature) E L Berryman

(Physician or midwife)

Address Buhl Ida

Filed 4-30 1930 J T Wurpell Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 76331

PLACE OF DEATH
County of Twin Falls
City of Buhl

CERTIFICATE OF DEATH

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

159 e

2. FULL NAME Mary Elizabeth Caummack

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 7th 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Idaho

PARENTS

10. NAME OF FATHER Francis Caummack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Dorthy Hudson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Buhl - Idaho

14. Informant O. S. Hudson
(Address) Buhl Ida.

15. Filed 4-17 1930 J. T. Wurtsley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 — 7 30
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7 30 to Apr 7 30
that I last saw Died during delivery 19 55
and that death occurred, on the date stated above, at 4 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Microcephalus - failure of development of occipital region
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? General
(Signed) E. L. Berry, M. D.
4-7 1930 (Address) Buhl

19. Place of Burial, Cremation, or Removal Buhl Idaho — Date of Burial 4/7 1930

20. Undertaker L. Johnson — Address Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**: **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.,** Carcinoma, Sarcoma, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

County of Valley

City of Cascade

No. 959 209 043 523 St.

STATE OF IDAHO

RECEIVED APR 19 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 180858

Registration District No. 15 File No.

Hospital Primary Registration District No. Registered No.

FULL NAME OF CHILD Infant Reid - Still Birth

(Certificate of no value without full name of child.)

Sex of Child Fem | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes. | Date of birth May 9 1930 (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of children of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	Sam Reid	FULL MAIDEN NAME	Helen Schrader
RESIDENCE	Cascade, Idaho	RESIDENCE	Cascade, Idaho
COLOR	White	COLOR	White
AGE AT LAST BIRTHDAY	43 (Years)	AGE AT LAST BIRTHDAY	20 (Years)
BIRTHPLACE	North Carolina	BIRTHPLACE	Caney Idaho
OCCUPATION	Miner	OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, Still Born, at 4 P.M. on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Sam Reid Father

(Physician or midwife)

Address Cascade, Idaho.

Give names added from a supplemental report.

192

Registrar.

Filed 192 Stella Cann

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED APR 19 1930
RECEIVED JUN 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71297

PLACE OF DEATH
County of Valley
City of Cascade

Registration District No. 15
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

206

2. FULL NAME Infant Reid —

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 9th 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cascade, Idaho

PARENTS
10. NAME OF FATHER Sam. Reid
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Frankline North Carolina
12. MAIDEN NAME OF MOTHER Helen Alexander
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cassy, Idaho

14. Informant Sam Reid
(Address) Cascade, Idaho

15. Filed March 9, 1930 Stella Cain, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Still birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Joyce E Ward M. D.
6/19/30, 19 (Address) Cascade Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Alpha - Idaho
Date of Burial: March 3/30 1930

20. Undertaker: None —
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. **If the information cannot be secured, it should be plainly stated unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon **the information of relatives** or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180873

PLACE OF BIRTH

County of Madison

City of Rexburg

No. ..... St.

343 220 033 294

(If born in hospital or institution give name.)

Registration District No. 100 State File No. .....

Prim. Registration District No. 278 Local Registrar's No. 83

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female					April 20 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 4 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Mark Lutz	FULL MAIDEN NAME Louisa Jumpson
Residence (Usual place of abode) Rexburg	Residence (Usual place of abode) Rexburg
If non-resident, give place and State	If non-resident, give place and State .....
Color or race W Age at last Birthday 23 (Years)	Color or race W Age at last Birthday 20 (Years)
Birthplace Rexburg Id (City and State or County)	Birthplace Salt Lake City Ut (City and State or County)
Occupation Section Foreman	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ **Stillborn at** ..... **M. on the date above stated.**

(Signature) H. B. Rigby M.D.

(Physician or midwife)

Address .....

Filed May 15 1930 J. Rayonna

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

[illegible]

[illegible]

FORM V. S. No. 5-25 M. 1-19.

MAY 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 70303
Local Registrar's No. 19

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.M.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Still Born

6. DATE OF BIRTH: Still Born April 20 1930 (Month) (Day) (Year)

7. AGE: Still Born Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF Father: Mark R. Lieth

11. BIRTHPLACE OF FATHER (State or Country): Rexburg

12. MAIDEN NAME OF MOTHER: Sarah L. Simpson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mark R. Lieth
(Address): Rexburg Idaho

15. Filed 4/20/ 1930 X J. H. Spoonr Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/30 1930, to April 20 1930, that I last saw h.— alive on Still born 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Still born
(Twins) 0 died other alive.

Chronic Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): High blood pressure Albuminuria in mother
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Rigby M. D.
April 20 1930 (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery — DATE OF BURIAL: 4/30 1930

20. UNDERTAKER: A. B. Henderson — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

2480

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH — MAY 16 1930

County of Madison

City of Sugar

No. ..... St. 213-18 033 - 249

(If born in hospital or institution, give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 186876

Registration District No. 100 State File No. .....

Prim. Registration District No. 2178 Local Registrar's No. 80

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate Yes | Date of birth 4 (Month) 18 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 2 Stillborn Stillborn

FATHER	MOTHER
FULL NAME Merced Baca	FULL MAIDEN NAME Juana Martinez
Residence (Usual place of abode) Sugar City	Residence (Usual place of abode) Sugar City
If non-resident, give place and State	If non-resident, give place and State
Color or race Brown Age at last Birthday 55 (Years)	Color or race Brown Age at last Birthday 35 (Years)
Birthplace Mexico (City and State or County)	Birthplace Mexico (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 8:20 P. M. on the date above stated.

(Signature) Lorin D. Neal

(Physician or ~~midwife~~)

Address Rexburg Idaho

Filed 5/15 1930 J. Myers Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

SB 1930 18(50)

FORM V. S. No. 5-25 M. 1-19

RECEIVED MAY 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 70202

Local Registrar's No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Baca

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word)

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7. AGE: Still Born — Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sugar City Idaho

10. NAME OF Father Mercede Baca

11. BIRTHPLACE OF FATHER (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Juanita Martinez

13. BIRTHPLACE OF MOTHER (State or Country) Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) McClyde
(Address) Rexburg Idaho

15. Filed 4/20 1930 J. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 — Still Born 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1930, to April 18 1930, that I last saw h. (M. alive) Lastseen 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Unknown
maceratio fortus
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

4/19 1930 (Signed) Lorne Ricks M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery — DATE OF BURIAL ..... 19...

20. UNDERTAKER: Eckersley — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 16 1930

PLACE OF BIRTH

County of Madison

City of Rexburg

No. ..... St.

253-211 033 866

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 180877

Registration District No. 100 State File No. .....

Prim. Registration District No. 2178 Local Registrar's No. 79

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	April 11, 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 4 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 2

FATHER		MOTHER	
FULL NAME	Orville Milton Bell	FULL MAIDEN NAME	Delora Anna Huff
Residence (Usual place of abode)	Rexburg	Residence (Usual place of abode)	Rexburg
If non-resident, give place and State		If non-resident, give place and State	
Color or race	W	Color or race	W
Age at last Birthday	31 (Years)	Age at last Birthday	29 (Years)
Birthplace (City and State or County)	Rexburg Idaho	Birthplace (City and State or County)	Idaho
Occupation	Auto Mechanic	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born Alive~~ Stillborn at 1:45 P. M. on the date above stated.

(Signature) H. B. Rigby M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address .....

Filed 5/15 1930 H. Rigby
Registrar.

PLACE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF [illegible]

No. _____ St.

Registration District No. _____ State File No. _____

Registration District No. _____ Local Registration District No. _____

FULL NAME OF CHILD _____

(To be signed by the attendant, substitute, or the mother, if child)

Sex of Child	Twin, triplet, or other	Number in order of birth (This assigned only in case of plural birth)	Length—inches	Date of birth (Month)	(Day)	(Year)

What prophylactic was used in prevent Ophthalmia Neonatorum?

Number of child of this mother including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____

FATHER

Full name _____

Residence _____

Residence, street and No. _____

If non-resident, province and town _____

Color or race _____ Age at last birthday _____ (years)

Birthplace _____ (City and state or country)

Occupation _____ Industry or business _____

Nationality _____

MOTHER

Maiden name _____

Residence, street and No. _____

If non-resident, province and town _____

Color or race _____ Age at last birthday _____ (years)

Birthplace _____ (City and state or country)

Occupation _____ Industry or business _____

Nationality _____

CERTIFICATE OF ATTENDANT OR PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive on the date above stated.

_____ (Sign here)

_____ (Physician or midwife)

Address _____

_____ M.D.

*If there was no attending physician or midwife, then the father, householder, or should such be the case, the mother of the child is the person, [illegible] shall be the person to provide other evidence of the birth.

RECEIVED JUN 9 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT
MAY 27 1930

Boise, Idaho

180877

Mrs. O.M. Bell
Rexburg

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Baby.

PLACE OF BIRTH Rexburg DATE OF BIRTH April 11, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 4
2. Number born alive and now living One.
3. Born alive but now dead One
4. Number of children stillborn two

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Orville Milton Bell (Full name)	Deloris ana ~~Bell~~ (Full maiden name)
373 1 N. 4 W. (Residence)	373 1 N. 4 W. (Residence)
Age at last birthday 21	Age at last birthday 28
Rexburg. Ida. (Birthplace)	Teton, Idaho. (Birthplace)
uto Mechanic. (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey

C.K. Macey
Special Agent, Bureau of the Census.

RECEIVED MAY 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70301

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

204

2. FULL NAME Baby Bell

(a) Residence. No. Rexburg St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg

PARENTS

10. NAME OF FATHER Oral Bell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rexburg Idaho
12. MAIDEN NAME OF MOTHER Delonis Struff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Teton Idaho

14. Informant Oral Bell
(Address) Rexburg Idaho

15. Filed 4/12, 1930. J. W. Rymmer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Born Dead April 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11, 19..., to April 11, 1930
that I last saw h... alive on ..., 19..
and that death occurred, on the date stated above, at not known
The CAUSE OF DEATH* was as follows:
(Stillborn)
(Hydrocephalus)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. B. Rigby, M. D.
April 12, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Teton Cemetery	April 12 1930
20. Undertaker	Address
C. W. Eckersell	Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

269-112-201-394

PLACE OF BIRTH RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

180981

County of Ada

City of Boise

No. ..... St.

Registration District No. 2

File No. .....

Hospital St. Luke's

Primary Registration District No. 1004

Registered No. 246

FULL NAME OF CHILD Donald DeVere Korup
(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
M	X (To be answered only in event of plural births)		X	yes	May 12 1930

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER	MOTHER
FULL NAME: Fred D. Korup	FULL MAIDEN NAME: Audrey L. Liddle
RESIDENCE: Boise	RESIDENCE: Boise
COLOR: White — AGE AT LAST BIRTHDAY 26 (Years)	COLOR: White — AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE: Idaho	BIRTHPLACE: Utah
OCCUPATION: Butcher	OCCUPATION: House-wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn (Born alive or stillborn), at 5.30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edward T. Binns M.D.

Physician
(Physician or midwife)

Address 202-203 Robert Noble Bldg. Boise

Give names added from a supplemental report.

....., 19.....

..... Registrar.

Filed 5-16 1930 W. H. Rhodes Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 10872

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 140

(No. St. Luke's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald De Lee Kamp

(a) Residence. No. 2410 Woodland Ave. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 5/12/30

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Boise

PARENTS

10. NAME OF FATHER: Fred Kamp

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Twin Falls Ida

12. MAIDEN NAME OF MOTHER: Audrey Liddle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City

14. Informant: Fred Kamp

(Address): Boise

15. Filed 5-15, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 12 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 12, 1930

that I last saw alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Arnold Blum, M. D.

May 12, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 5/12 1930

20. Undertaker: Schreiber & McCann | Address: Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (**secondary** or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham

City of Shelley

No. ..... St.

465-28-006-713

(If born in hospital or institution give name.)

JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181067

Registration District No. 121 State File No. .....

Prim. Registration District No. 2194 Local Registrar's No. 165

FULL NAME OF CHILD Stillbirth Manson.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	May 13 — 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Nilas N. Manson	FULL MAIDEN NAME Pack
Residence (Usual place of abode) Shelley Idaho	Residence (Usual place of abode) Shelley Ida.
If non-resident, give place and State	If non-resident, give place and State .....
Color or race ..... Age at last Birthday ..... (Years)	Color or race White Age at last Birthday ..... (Years)
Birthplace ..... (City and State or County)	Birthplace ..... (City and State or County)
Occupation Farmer	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 8 P. M. on the date above stated.

(Signature) [illegible] M.D.

(Physician or ~~Midwife~~)

Address Shelley Ida

Filed June 6 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 24418

PLACE OF DEATH

County of Bingham

City of Shelley Idaho

Registration District No. 127

Primary Registration District No. 2174

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

204

2. FULL NAME Florence Monson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 13 1930

7. AGE: Years: Still Born; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelley Idaho

PARENTS

10. NAME OF FATHER: Nels N. Monson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Raburg Idaho

12. MAIDEN NAME OF MOTHER: Florence Peck

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Richmond Utah

14. Informant: Nels N. Monson
(Address): Shelley Route-2

15. Filed May 15, 1930 Mrs Nellie E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1930, to May 13 1930, that I last saw him alive on May 13 1930 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Exencephalus

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): None

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. W. Poole M. D.

May 14th, 1930 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Goshen Cemetery	May 14 1930
20. Undertaker	Address
None	5-15-30

13.

MAR 29 2006

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham

City of Blackfoot

No. ..... St.

892-102-006-238

(If born in hospital or institution give name.)

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 181097

Registration District No. 121 State File No. .....

Prim. Registration District No. 1007 Local Registrar's No. 138

FULL NAME OF CHILD Unnamed Hibbert

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	May 2 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Mercurochrome

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Gerald Lloyde Hibbert	FULL MAIDEN NAME Mary Alice Schiess
Residence (Usual place of abode) Blackfoot Ida	Residence (Usual place of abode) Blackfoot Ida
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday (Years)	Color or race White Age at last Birthday (Years)
Birthplace Utah (City and State or Country)	Birthplace Utah (City and State or Country)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 4-50 p. M. on the date above stated.

(Signature) W W Beck

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Blackfoot, Idaho

Filed June 2 1930 Mrs Thalia E Patrick

Registrar.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Bingham

City of Blackfoot, Ida

Registration District No. 27

Primary Registration District No. 1007

Local Registrar's No. 58

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Hibbert

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year): May 7, 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Ida

PARENTS

10. NAME OF FATHER: Gerald Clyde Hibbert

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Alice Schiess

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Gerald Hibbert
(Address): Blackfoot

15. Filed: May 3, 1930 Mo Valentine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Stillborn May 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stillborn, 19..., to May 7, 1930
that I last saw h. ..... alive on ....., 19...
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Thrombosis of Cord
Had been dead several days
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W W Beck M. D.

5/3, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Brower City Cemetery — Date of Burial: 5-3-30

20. Undertaker: Modern Mortuary — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18/097

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

181104

PLACE OF BIRTH
County of Bingham
City of Shelley
No. ..... St.
154-104006-253
(If born in hospital or institution give name.)

Registration District No. 121 State File No.
Prim. Registration District No. 2194 Local Registrar's No. 131

FULL NAME OF CHILD Stillborn Anderson.
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth May (Month) 4 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% Argyrol

Number of child of this mother, including present birth 2 (a) Born alive and now living
Born alive but now dead — Stillborn 1

FATHER
FULL NAME Geo. R. Anderson
Residence (Usual place of abode) Shelley, Idaho
If nonresident, give place and State
Color or race white Age at last Birthday 26 (Years)
Birthplace Salem, Idaho (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Pearl Kelley
Residence (Usual place of abode) Shelley, Idaho
If nonresident, give place and State
Color or race white Age at last Birthday 25 (Years)
Birthplace Shelley, Idaho (City and State or Country)
Occupation Housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 8:15 a. M. on the date above stated.

(Signature) Edwin Cutler M.D.
(Physician ~~or midwife~~)
Address Shelley Idaho

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed June 1 1930 Walter E. Tabler
Registrar.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Shelly, Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2142

File No. .....

Registered No. 61

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write this word.)~~ Single

6. DATE OF BIRTH: 5 (Month) 4 (Day) 1930 (Year)

7. AGE: Still Born Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ——
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Shelley Idaho.

10. NAME OF FATHER: Geo. R. Anderson.

11. BIRTHPLACE OF FATHER (State or Country): Salem Idaho.

12. MAIDEN NAME OF MOTHER: Pearl Keiley

13. BIRTHPLACE OF MOTHER (State or Country): Shelley Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. R. Anderson
(Address) Shelley Ida

15. Filed ..... 19.. Mrs Willis E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) – 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-4-1930, to 5-4-1930, that I last saw h. ~~alive on~~ ..... 19.., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Still birth of several weeks standing

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) See other side

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.

5-4-1930 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? At home

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 5-4-1930

20. UNDERTAKER: None — ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

181104

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

The period of gestation was about 6½ or 7 months. Though the child had been dead probably 2 or 3 weeks.
The cause is at present unknown while the mother was not in perfect health there was no evidence of nephritis. Blood pathology though no urine examination has yet been made. About 10 yrs ago the mother was operated for ovarian cyst and all but a small piece of ovary left. A cyst of a left ovary was removed

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S181158

PLACE OF BIRTH
County of Bonneville
City of Idaho Falls, Idaho
No. 219 2030 10 556 St.
L.D.S. Hospital
(If born in hospital or institution give name.)

Registration District No. 73 State File No.
Prim. Registration District No. 2 1 2 0 Local Registrar's No. 124

FULL NAME OF CHILD "Stillbirth" Barnes
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Apr. (Month) 3 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? [redacted]

Number of child of this mother, including present birth 5 (a) Born alive and now living 3
Born alive but now dead 0 Stillborn 2

FATHER	MOTHER
FULL NAME Wm. James Barnes	FULL MAIDEN NAME Thora Newman
Residence (Usual place of abode) Milo	Residence (Usual place of abode) Milo
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 32 (Years)	Color or race White Age at last Birthday 27 (Years)
Birthplace Idaho Falls, Idaho (City and State or County)	Birthplace Housewife (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 1:18 P.M. on the date above stated.
Ceasarian

(Signature) [signature]
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho Falls, Idaho
Filed [illegible], V 1930 [signature]
Registrar.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10175

PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Idaho

Registration District No. 73
Primary Registration District No. 2147
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6 A

1 206

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): April 3, 1930
7. AGE: Stillborn — Years; Months: ---; Days: ---; If LESS than 1 day, ---- hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho L.D.S. Hospital

PARENTS
10. NAME OF FATHER: William James Barnes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho Falls, Idaho
12. MAIDEN NAME OF MOTHER: Thora Newman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Milo, Idaho

14. Informant: Mrs. William James Barnes
(Address): Rigby R#2

15. Filed: April 9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 3, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 3, 1930
that I last saw her alive on April 3, 1930
and that death occurred, on the date stated above, at 2:00 P. m.
The CAUSE OF DEATH* was as follows:
Asphixiation due to premature separation of placenta in utero
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Premature 8 Months uterо
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rigby R#2
Did an operation precede death? No Date of
Was there an autopsy? Ceasarian Section
What test confirmed diagnosis? on mother.
(Signed) [signature], M. D.
April 4, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cremation at L.D.S. Hospital — Date of ~~Burial~~ 3 1930
20. Undertaker: [signature] — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18/1158 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. 355-225 01 0843 St.

L. Ds S. Hospital

(If born in hospital or institution give name.)

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181168

Registration District No. 73 State File No.

Prim. Registration District No. 210 Local Registrar's No. 167

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? / (To be answered only in event of plural births) | and | Number in order of birth | Legitimate? Yes | Date of birth Apr (Month) 25 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Wilford D. Lee	FULL MAIDEN NAME Lorene Hutchinson
Residence (Usual place of abode) Iona, Idaho	Residence (Usual place of abode) Iona, Idaho
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 31 (Years)	Color or race White Age at last Birthday 25 (Years)
Birthplace Iona, Idaho (City and State or Country)	Birthplace Winnepeg (City and State or Country)
Occupation School Teacher	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 12-07 P. M. on the date above stated.

(Signature) [signature]

Physician
(Physician or midwife)

Address Idaho Falls, Idaho

Filed May 24 1930 [signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2110
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

2010

2. FULL NAME Still born
(a) Residence. No. Idaho Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Organs.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years | Months: still birth | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) —

PARENTS
10. NAME OF FATHER Milford D. Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iona
12. MAIDEN NAME OF MOTHER Madine Hutchinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stumpy Canada

14. Informant Father. Milford A. Lee
(Address) Idaho Falls

15. Filed April 24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to April 25, 1930 that I last saw h. alive on April 25, 1930 and that death occurred, on the date stated above, at 12:40 P. m.
The CAUSE OF DEATH* was as follows:
Tumor growth of Placenta.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
April 25, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cremation | Date of Burial: April 28 1930
20. Undertaker: none | Address

18/169 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. 355-105010-391 St.

L.D.S. Hospital

(If born in hospital or institution give name.)

REGISTERED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

181187

CERTIFICATE OF BIRTH

S

Registration District No. 33 State File No.

Prim. Registration District No. 210 Local Registrar's No. 134

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth April 5 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 12 (a) Born alive and now living 9

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Oren Ward Lee	FULL MAIDEN NAME Lydia Frances Tracy
Residence (Usual place of abode) Osgood Idaho	Residence (Usual place of abode) Osgood
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 41 (Years)	Color or race White Age at last Birthday 39 (Years)
Birthplace Milo Idaho (City and State or County)	Birthplace Ogden Utah (City and State or County)
Occupation Farming	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 4:25 A. M. on the date above stated.

(Signature) [illegible]

Physician & Surgeon
(Physician or midwife)

Address Idaho Falls Idaho

Filed May 9 1930 [illegible]
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. _____

Place of Death: County _____ City _____

Registration District No. _____

Primary Registration District No. _____

Local Registrar's No. _____

1. PLACE OF DEATH

(If within a hospital or other institution, give name, not street address)

Sex of Child | Twin, triplet, or quadruplet | Single, twin, triplet, or quadruplet | Number in order of birth | Single, twin, triplet, or quadruplet | Number in order of birth

(Leave blank if not a twin or triplet)

Hour of Birth _____ (Hours)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother including present child: (a) Born alive and now living _____

Born alive but now dead _____

(b) Born alive but now dead _____

	FATHER	MOTHER
FULL NAME		
MAIDEN NAME		
Residence (Number and street)		
Residence (City or town)		
Residence (County)		
Residence (State)		
Color or race	Age at last birthday (Years)	Age at last birthday (Years)
Birthplace (State or country)		
Occupation		
Industry		
Birthplace (City and state or country)		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ M. on the date above stated.

(Signature)

(Address)

If no physician was in attendance, please give name of midwife, then the father, householder, etc. Should more than one live child be born at this birth, give name of physician or midwife.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10433

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): April 5, 1930
7. AGE: Years: Stillborn; Months: ; Days: ; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS
10. NAME OF FATHER: Owen Ward Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Milo
12. MAIDEN NAME OF MOTHER: Lydia Frances Tracy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden, Utah

14. Informant: Orson Ward Lee
(Address): Idaho Falls R 2 Box 7

15. Filed May 4, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h. alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Premature birth 7 Mos
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Placenta Previa in Mother
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Milo Idaho — Date of Burial: May 6/30 19
20. Undertaker: [illegible] — Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

+ 1831

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Canyon

City of Caldwell

No. 419 21201 4231 St. Caldwell Sanitarium

(If born in hospital or institution give name.)

JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181209

Registration District No. 3 State File No.

Prim. Registration District No. 2005 Local Registrar's No. 88

FULL NAME OF CHILD Stillbirth.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) 19 (Year)
Girl				Yes	5/12/30

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME F. E. Marchek	FULL MAIDEN NAME Beatrice Stagg
Residence (Usual place of abode) Harper, Oregon	Residence (Usual place of abode) Harper, Oregon
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 25 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Wyoming (City and State or Country)	Birthplace Utah (City and State or Country)
Occupation Farming	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born Alive / Stillborn} at 11:45 P M. on the date above stated.

(Signature) F.M.Cole
M. D.
(Physician or midwife)

Address Caldwell, Idaho

Filed 5-15- 1930 John S. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 1513

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
Local Registrar's No. 52

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Marchek

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER Frank Marchek
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Wyoming
12. MAIDEN NAME OF MOTHER Beatrice Stagg
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah

14. Informant Frank Marchek
(Address) Harper Oregon

15. Filed 5-13-, 1930. John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12, 1930
(Month) (Day) 19.....(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to ....., 19.....
that I last saw h. alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Unknown

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary) .....
(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

5/13, 1930 (Signed) J. M. Case, M. D.
(Address) Caldwell

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 5-13-30 19

20. Undertaker: Paul L. Case
Address: Caldwell, Id

13209

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

296 209 014982

PLACE OF BIRTH

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

181250

County of Canyon

City of Nampa

No. ..... St.

Registration District No. 7 File No. .....

Hospital .....

Primary Registration District No. 1056 Registered No. 108

FULL NAME OF CHILD Arbie Lazer Brownfield
(Certificate of no value without full name of child.)

Sex of Child Male

Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth

Legitimate? Yes

Date of birth May 9 1930 (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth ONE Number of child of this mother now living, including present birth NONE

FATHER		MOTHER	
FULL NAME	Earl Edward Brownfield	FULL MAIDEN NAME	Cora May Roby
RESIDENCE	Nampa	RESIDENCE	~~Oregon~~ Nampa
COLOR	White	COLOR	White
AGE AT LAST BIRTHDAY	27 (Years)	AGE AT LAST BIRTHDAY	28 (Years)
BIRTHPLACE	Illinois	BIRTHPLACE	Oregon
OCCUPATION	Laborer	OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born 8:00 P. M. (Born alive or stillborn) on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. R. Meredith M.D.
(Physician or midwife)

Address .....

Give names added from a supplemental report.

....., 19....

..... Registrar.

Filed June 1 1930 Esther Conway Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70500

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 58

2. FULL NAME Inf, daughter of Mr and Mrs, Earl Brownfield
(a) Residence. No. 1605-3 st. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Daughter of Mr.and Mrs. Brownfield
6. DATE OF BIRTH (month, day and year): May 9, 1930
7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Nampa Ida.

PARENTS
10. NAME OF FATHER: Earl Brownfield
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Cora M.Roby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ore.

14. Informant: Earl Brownfield
(Address) 1605 3st No.

15. Filed 5-10, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from at birth to ....., 19..
that I last saw h..... alive on May 9, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Difficult delivery
via Abs forceps
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) did not breathe
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C.W. Meredith D.C. M. D.
May 10, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn — Date of Burial: 19
20. Undertaker: F. K. Robinson — Address: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18/250 7

m.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, **as Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull,** and consequences **(e. g. sepsis, tetanus)** may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 5 1930

PLACE OF BIRTH
County of Lewis
City of Winchester
No. ..... St.
712 219 031 652
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

181453

Registration District No. 60 State File No. .....
Prim., Registration District No. 219 Local Registrar's No. 20

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
F				yes	May 19 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 9 (a) Born alive and now living 8
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Jacob Gaiser	FULL MAIDEN NAME Rosie Wescott
Residence (Usual place of abode) Winchester	Residence (Usual place of abode) Winchester
If nonresident, give place and State	If nonresident, give place and State .....
Color or race W Age at last Birthday 53 (Years)	Color or race W Age at last Birthday 40 (Years)
Birthplace Germany (City and State or Country)	Birthplace North Dakota (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 5:30 P M. on the date above stated.

(Signature) Ralph M. Alley M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Winchester Idaho.

Filed 6/24 1930 P. E. Burnett
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Print. Local Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of child	Twin, triplet, or other	Number in order of birth	Legitimate or illegitimate	Date of birth (Month)	(Day)	(Year)

What prophylactic was used in preventing ophthalmia neonatorum _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

(b) Born alive but now dead _____ Stillborn _____

FATHER

FULL NAME _____ COLOR OR RACE _____ AGE _____

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race _____ Age at last Birthday _____ (Years)

Birthplace _____ (City and State or Country)

Occupation _____

MOTHER

FULL NAME _____ COLOR OR RACE _____ AGE _____

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race _____ Age at last Birthday _____ (Years)

Birthplace _____ (City and State or Country)

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at _____ M. on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

*Where there was no attending physician or midwife, then the father, householder, or other person should make this return. A stillbirth should be reported only if there is no other evidence of live birth.

IMPORTANT WITH THE PARENTS—THIS IS A LEGAL DOCUMENT
In case of more than one child, print one certificate for each child.
Sign and file in order of birth, in accordance with the instructions.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Lewis

City of Winchester

Registration District No. 60

Primary Registration District No. 2129

Local Registrar's No. 8

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2.04

2. FULL NAME Still Birth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6. DATE OF BIRTH (month, day and year): May 19, 1930

7. AGE: Years | Months | Days: Full Term | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Winchester, Ida.

PARENTS

10. NAME OF FATHER: Jacob Gaiser

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Bessie Westcott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Dakota

14. Informant: Jacob Gaiser
(Address): Winchester, Idaho

15. Filed 6/4, 1930. R. E. Dunlap Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased from~~ on May 19, 1930, to ....., 19..... that I last saw h~~e~~ alive on May 19, 1930 and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Still Birth.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shoulder Presentation. Dif. Delivery. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ralph M. Alley, M. D.

May 20, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Winchester Ida — Date of Burial: 6/20 1930

20. Undertaker: J. Gaiser — Address: Winchester

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked** on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, **as Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a **midwife.**

PLACE OF BIRTH

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 81540

County of Nez Perce

City of Lewiston

No. 367 220035 4242 St. Registration District No. 96 State File No.

Hospital St. Josephs Primary Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD Patricia Cox.

(Certificate of no value without full name of child)

Sex of Child female | Twin Triplet or other? — and Number in order of birth — (To be answered only in event of plural births) | Legitimate? yes. | Date of birth May 20 1930 (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	Whitman Cox	FULL MAIDEN NAME	Beatrice Musgrave
RESIDENCE	Lewiston Ida	RESIDENCE	Same
COLOR	white	COLOR	white
AGE AT LAST BIRTHDAY (Years)	20	AGE AT LAST BIRTHDAY (Years)	21
BIRTHPLACE	Ida	BIRTHPLACE	Wash.
OCCUPATION	Laborer	OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 11 20 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) William P. Hall M.D.

(Physician or ~~midwife~~)

Address Lewiston Idaho

Give names added from a supplemental report.

....., 192...

Registrar.

Filed 6-1 1930 J. M. Lyle

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

181540

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7[illegible]

Local Registrar's No.

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

2. FULL NAME Patricia Lee Cox.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20th, 1930.

7. AGE: Years -0- Months -0- Days -0- If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, (State or country) Idaho.

PARENTS

10. NAME OF FATHER Whitman B. Cox.

11. BIRTHPLACE OF FATHER (city or town) Lewiston, (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Mary Beatrice Musgrave.

13. BIRTHPLACE OF MOTHER (city or town) Walla Walla, (State or Country) Washington.

14. Informant Whitman B. Cox.
(Address) Lewiston, Idaho.

15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Asphyxia.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Umbilical Cord.

(duration) yrs. mos.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Pittard, M.

5/21/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho.

Date of Burial: 5/22/30. 19

20. Undertaker: Brower-Wann Company.

Address: Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

316122-035-291

PLACE OF BIRTH

RECEIVED JUN 17 1930

County of

City of Lewiston

No. St.

St Joseph's Hosp

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Registration District No. 96 State File No. 181562

Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD William Lawrence

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male				yes	4 22 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? 2% silver nitrate

Number of child of this mother, including present birth 2 (a) Born alive and now living 2

Born alive but now dead Stillborn

FATHER		MOTHER	
FULL NAME	H. Lawrence	FULL MAIDEN NAME	Ellen Brunskeau
Residence (Usual place of abode)	Cuddesac	Residence (Usual place of abode)	Cuddesac
If nonresident, give place and State		If nonresident, give place and State	
Color or race	Indian	Color or race	Indian
Age at last Birthday (Years)	47	Age at last Birthday (Years)	35
Birthplace (City and State or Country)	Cuddesac	Birthplace (City and State or Country)	Cuddesac
Occupation	Farmer	Occupation	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was [redacted] Stillborn at 7:45 P. M. on the date above stated.

(Signature) O. C. Carrico

Lewiston Idaho

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed Jan 1 1930 Susan E Bruce

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

nOD

249-213-040-215

PLACE OF BIRTH

County of Shoshone

City of Wallace

No. ..... St.

(If born in hospital or institution give name.) Providence

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181623

Registration District No. 70 State File No. .....

Prim. Registration District No. 101 Local Registrar's No. 35

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child F | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth 4 - 17 - 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead ..... Stillborn 2

FATHER	MOTHER
FULL NAME Chester H Smiley	FULL MAIDEN NAME Mary Banks
Residence (Usual place of abode) Burke, Ida	Residence (Usual place of abode) Burke Ida
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 25 (Years)	Color or race White Age at last Birthday 19 (Years)
Birthplace Kissee Mills, Mo. (City and State or Country)	Birthplace Porter, Okla (City and State or Country)
Occupation Miner	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 12:40 P. M. on the date above stated.

(Signature) D H Mowery

Physician

(Physician or midwife)

Address Wallace, Ida

Filed May 5 1930 E. L. Quigley

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

*When there was no attending physician or midwife, the parents, householder, etc., should report the birth. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 14

(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

2. FULL NAME Infant of Chester H. Smiley

(a) Residence. No. Burke, Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) Wallace (State or country) Idaho

PARENTS

10. NAME OF FATHER Chester H. Smiley

11. BIRTHPLACE OF FATHER (city or town) Kissee Mills (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mary Banks

13. BIRTHPLACE OF MOTHER (city or town) Porter (State or Country) Oklahoma

14. Informant Chester H. Smiley

(Address) Burke, Idaho

15. Filed 4-14, 1930 T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) (Day) 17 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Monstrosity

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Morrell, M. D.

4/18, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Idaho | Date of Burial: April 19 1930.

20. Undertaker: Bruce E. Worstell | Address: Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 6 1930

PLACE OF BIRTH

County of Shoshone

City of Kellogg

No. ..... St. 469 718 040 235

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 181631

Registration District No. 123 State File No.

Prim. Registration District No. 2204 Local Registrar's No. 60

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male.		yes	May 18 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn May 18th.

FATHER	MOTHER
FULL NAME Henry Doerndorf	FULL MAIDEN NAME Wilomina Bleiner
Residence (Usual place of abode) Kellogg, Idaho	Residence (Usual place of abode) Kellogg, Idaho
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 34 (Years)	Color or race White Age at last Birthday 27 (Years)
Birthplace Minnesota (City and State or Country)	Birthplace ~~Ida~~ Idaho (City and State or Country)
Occupation	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 2 9 M. on the date above stated.

(Signature) W. L. Gridley

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Kellogg Idaho

Filed May 20 19[redacted] Mrs. Helen M. Bride

Registrar.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 16631

Registration District No. ..... State File No. .....

Print Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child	Twins or triplets (To be answered only in case of plural births)	Order of birth (To be answered only in case of plural births)	Length (inches)	Date of birth (Month)	19.. (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living ..... (b) Born alive but now dead ..... (c) Stillborn .....

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME .....
Residence (Usual place of abode)	Residence (Usual place of abode) .....
If nonresident, give place and state	If nonresident, give place and State .....
Color or race ..... Age at last Birthday ..... (Years)	Color or race ..... Age at last Birthday .....
Birthplace ..... (City and State or Country)	Birthplace ..... (City and State or Country)
Occupation	Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at ..... M. on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19.. .....

(Registrar)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that was neither breathe nor showed other evidence of life after birth.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 28

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Loeserndorf

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: M.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kellogg Idaho

PARENTS

10. NAME OF FATHER: Henry Loeserndorf

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Mina Bliesner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Husband of mother
(Address) Kellogg, Idaho

15. Filed May 30, 1930 Mrs. Ken McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18th, 1930; to, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Still born. Albuminuria on part of mother.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Maceration of body

(Signed) W. L. Lindsay, M. D.

May 21, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho — Date of Burial: May 20 1930

20. Undertaker: M. P. Thornhill — Address: Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered **as Housewife, Housework or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH JUN 9 1930

County of [illegible]

City of [illegible]

No. [illegible] St.

Twin Falls Co. Gen. Hosp.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 37 State File No. S [illegible]658

Prim. Registration District No. 2085 Local Registrar's No.

FULL NAME OF CHILD Elma Mayer
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	5 - 24 - 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 11 (a) Born alive and now living 10

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Nelham Reuben Mayer	FULL MAIDEN NAME	Minnie Boise Lahen
Residence (Usual place of abode)	Mustaugh, Ida	Residence (Usual place of abode)	Mustaugh Ida
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	43	Age at last Birthday (Years)	39
Birthplace (City and State or Country)	Huntsville, Utah	Birthplace (City and State or Country)	St. Charles, Idaho
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / Stillborn at 8 15 a. M. on the date above stated.

(Signature) J. H. Davis
(Physician or midwife)

Address Kimberly Idaho

Filed 6 - 4 - 1930 Elizabeth J. Smith
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[redacted]

245 709 042 381

RECEIVED JUN 9 1930

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. ..... St.

Twin Falls Co. Gill Hosp

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181675

Registration District No. 37 State File No. .....

Prim. Registration District No. 2085 Local Registrar's No. .....

FULL NAME OF CHILD Thomas Adolph Kinkel

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	5 - 9 - 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Dale DeForest Kinkel	FULL MAIDEN NAME	Vivian Chandler
Residence (Usual place of abode)	Amsterdam	Residence (Usual place of abode)	Amsterdam, Ida
If nonresident, give place and State	Idaho.	If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	38	Age at last Birthday (Years)	34
Birthplace (City and State or Country)	Oak County - Missouri	Birthplace (City and State or Country)	Chicago - Ill.
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 6 40 P. M. on the date above stated.

(Signature) Charles R. Scott

(Physician or ~~midwife~~)

Address Twin Falls - Idaho.

Filed 6 - 9 - 1930 Elizabeth J. Smith

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

[illegible]

[illegible]

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. .....

Local Registrar's No. .....

Registration District No. 37

Primary Registration District No. 2085

(No. .....)

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Thos. Adolph Bankel

(a) Residence. No. Amsterdam Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days —

If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Still Born

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: D. D. Bankel

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Ruth E. Sandler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: D. D. Bankel
(Address) Amsterdam Idaho

15. Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 1930 (10-30)
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Oligohydramnion.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Charles R. Scott, M. D.

May 10, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: May 10 1930

20. Undertaker: O. E. Drake — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

181675 A

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Do not accept a certificate of death signed only by a midwife.

1920

697111044815

PLACE OF BIRTH — JUN 14 1930

County of Washington

City of Weiser

No. ..... St.

Mowhead

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 181696

Registration District No. 86 State File No.

Prim. Registration District No. 1010 Local Registrar's No. 27

FULL NAME OF CHILD Gene Wiggins

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male			yes	3 - 11 - 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? ~~Cr Ag 3 1/2 cc~~

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Homer Wiggins	FULL MAIDEN NAME	Elsie Yancey
Residence (Usual place of abode)		Residence (Usual place of abode)	
If non-resident, give place and State	Michvale Ida.	If non-resident, give place and State	Michvale Ida.
Color or race	White	Color or race	White
Age at last Birthday (Years)	23	Age at last Birthday (Years)	20
Birthplace (City and State or County)	Michvale Ida	Birthplace (City and State or County)	Salem Mo
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 11 A. M. on the date above stated.

(Signature) Ernest A. Finney

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 5/5/30 19 M. R. Hamilton

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70043

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1910
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

2. FULL NAME Gene Wiggins
(a) Residence. No. Midvale Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Stillborn
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years — Months — Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Weiser. Idaho

PARENTS
10. NAME OF FATHER: Homer Wiggins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Elsie Gaukey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Homer Wiggins
(Address): Midvale Idaho
15. Filed Mch 14th, 1930. W. R. Hunton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Premature Still Birth at 7½ mo. (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Toxic Kidney Nephritis (duration) yrs. 5 mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Cecil O. Tilley M. D.
3-11-, 1930 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Midvale Idaho — Date of Burial: 3-12-1930
20. Undertaker: R. C. Northern — Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18/696

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

396-110-001-466

RECEIVED JUL 9 1930

PLACE OF BIRTH

County of .....

City of .....

No. ..... St.

St. Rokes

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

181785

Registration District No. 3 State File No. .....

Prim. Registration District No. 1004 Local Registrar's No. 280

FULL NAME OF CHILD (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
M				Y	June 10 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 5 (a) Born alive and now living 1

Born alive but now dead — Stillborn 4

FATHER	MOTHER
FULL NAME Ward A. Fropl	FULL MAIDEN NAME Alpha Mooney
Residence (Usual place of abode) 2315 Woodlawn	Residence (Usual place of abode) 2315 Woodlawn
If non-resident, give place and State	If non-resident, give place and State .....
Color or race W Age at last Birthday 40 (Years)	Color or race W Age at last Birthday 38 (Years)
Birthplace Missouri (City and State or County)	Birthplace Missouri (City and State or County)
Occupation Clerk	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 2⁰⁰ P.M. on the date above stated.

(Signature) A. J. Coates

(Physician or midwife)

Address 521 Eastman Bldg

Filed 6-10-1930 W. A. Rhodes Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Dr Coats.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70771

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 173

(No. St Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Melvin Kenneth Troxel.

(a) Residence. No. 2315. Woodlawn Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June. 10.1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	0 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Ward. A. Troxel.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Alpha. B. Mooney.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant Ward. A. Troxel.
(Address) 2315. Woodlawn St, Boise, Idaho.

15. Filed 6-10, 1930 W. H. Rodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June, 10, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw him alive on ..., 19...
and that death occurred, on the date stated above, at 2 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Oversized Fetus

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A J Coats, M. D.
6/10, 1930 (Address) Boise.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: June. 10. 1930.

20. Undertaker: Summers & Krebs. Address: Boise, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 2 1930

PLACE OF BIRTH

County of Bannock

City of Lava Hot Springs

No. ..... St.

236-115-003-764
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 181820**

Registration District No. 84 State File No. .....

Prim. Registration District No. 216 Local Registrar's No. 788

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	June 15 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME John Merle Bloxham	FULL MAIDEN NAME Linda Verina Godfrey
Residence (Usual place of abode) Lava H S	Residence (Usual place of abode) Lava Hot Springs
If nonresident, give place and State	If nonresident, give place and State .....
Color or race White Age at last Birthday 33 (Years)	Color or race White Age at last Birthday 29 (Years)
Birthplace Downey Ida (City and State or Country)	Birthplace Brigham City Utah (City and State or Country)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 7 45 A. M. on the date above stated.

(Signature) C. A. Rich M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Lava Hot Springs Ida

Filed June 30 1930 Mrs. G. G. Fitt
Registrar.

STATE OF ILLINOIS

DEPARTMENT OF PUBLIC HEALTH

BUREAU OF VITAL RECORDS

CERTIFICATE OF BIRTH

County of .....

City of .....

No. .....

Registration District No. ..... State File No. .....

Ward or Township .....

Date Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of child	Single, twin, triplet, etc.	Number in order of birth	Legitimate?	Date of birth	Hour of birth

(Fill in answers only in case of actual birth)

Attending physician or other person in charge of case ..... (a) Born alive and now living ..... (b) Born alive and now dead ..... Stillborn .....

FATHER	MOTHER
Full Maiden Name	
Residence (Usual place of abode)	Residence (Usual place of abode)
If nonresident, give place and state	If nonresident, give place and state
Color or race ..... Age at last Birthday ..... (Years)	Color or race ..... Age at last Birthday ..... (Years)
Birthplace (City and State or Country)	Birthplace (City and State or Country)
Occupation	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { born alive / Stillborn } at ..... on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19.....

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70822

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs
Registration District No. 84
Primary Registration District No. 2161
Local Registrar's No. 186
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth
(a) Residence. No. Lava Hot Springs St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

note

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, 0 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Lava Hot Springs Idaho

PARENTS
10. NAME OF FATHER John Merle Bloxham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Downey Idaho
12. MAIDEN NAME OF MOTHER Linda Verna Godfrey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Brigham City Utah

14. Informant John Merl Bloxham
(Address) Lava Hot Springs By C. A. Rich
15. Filed June 30, 1930 Mrs. G. I. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from at birth June 15, 1930 to — 19
that I last saw h— alive on Never lived 19
and that death occurred, on the date stated above, at 7:45 a.m.
The CAUSE OF DEATH* was as follows: Unknown (Died in utero at 6 mo gestation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) C. A. Rich M. D.
6-15, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

181820 + 0

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 2 1930

PLACE OF BIRTH

County of Bannock

City of Chesterfield

No. ..... St.

539 166 403 266

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181822

Registration District No. 84 State File No. ....

Prim. Registration District No. 2161 Local Registrar's No. 786

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male		Yes	June 6 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? ....

Number of child of this mother, including present birth 1 (a) Born alive and now living ....

Born alive but now dead .... Stillborn 1

FATHER		MOTHER	
FULL NAME	Joseph Godfrey Eliason	FULL MAIDEN NAME	Ruby Bowman
Residence (Usual place of abode)	Bancroft	Residence (Usual place of abode)	Bancroft Ida
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	28	Age at last Birthday (Years)	23
Birthplace (City and State or Country)	Logan Utah	Birthplace (City and State or Country)	Chesterfield Idaho
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 2:30 A M. on the date above stated.

(Signature) G G Fitz M D

(Physician or midwife)

Address Bancroft Idaho

Filed June 30 1930 Mrs. G. G. Fitz

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WHITE PLAINLY WITH PRESSING INK—THIS IS A REGISTRATION RECORD

N.B.—If more than one child is born at one birth, a separate certificate should be made for each and the number of the birth should be entered in the space provided.

CERTIFICATE OF BIRTH

County of .....

City of .....

No. .....

Registration District No. ..... State File No. .....

(If born in hospital or institution give name)

Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillborn" for name of child)

Sex ..... Twin or triplet? (To be answered only in event of plural birth) ..... Legitimate or illegitimate? ..... Date of birth ..... (Month) ..... (Day) ..... (Year) 19..

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME .....
Residence (Usual place of abode)	Residence (Usual place of abode) .....
If unavailable, give town and State	If unavailable, give place and State .....
Color or race ..... Age at last Birthday ..... (Years)	Color or race ..... Age at last Birthday ..... (Years)
Birthplace ..... (City and State or Country)	Birthplace ..... (City and State or Country)
Occupation	Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / stillborn on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19..

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Registrar

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70824

PLACE OF DEATH

County of Bannock

City of Chesterfield

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 2161

(No. .....)

Local Registrar's No. 184

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Still Birth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 6 - 1930

7 AGE Years | Months | Days | If LESS than 1 day, 0 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chesterfield Ida

PARENTS

10 NAME OF FATHER Joseph Godfrey Eliason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Logan Utah

12 MAIDEN NAME OF MOTHER Ruby Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chesterfield Idaho

14 Informant Mrs J. G. Eliason

(Address) Bancroft Ida

15 Filed June 30, 1930 Mrs G G Fitz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June - 6 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to at birth, 19....,
that I last saw h..... alive on never lived, 19....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Unknown
About 5 or 6 months ~~Sick~~
pregnant
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) G. G. Fitz, M. D.

June 7, 1930 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. **The date of** death should be the date of delivery and the death **certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.**

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is **indefinite**); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis,** tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

34 3 1/2 - 207 - 313

PLACE RECEIVED JUL 10 1930

County of Bannock

City of Pocatello

No. St. Anthony St.

Hosp.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181864

Registration District No. ..... State File No. .....

Prim. Registration District No. 161 Local Registrar's No. 985

FULL NAME OF CHILD Stillborn (Cullen)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male			Yes	6 - 12 - 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER	MOTHER
FULL NAME Lawrence Cullen	FULL MAIDEN NAME Adeline Talcott
Residence (Usual place of abode) 320 N. Grant	Residence (Usual place of abode) 320 N. Grant
If non-resident, give place and State	If non-resident, give place and State
Color or race W. Age at last Birthday 31 (Years)	Color or race W. Age at last Birthday 23 (Years)
Birthplace Minadoka Ida (City and State or County)	Birthplace Kemmerer Wyo (City and State or County)
Occupation Carpenter	Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 2 55 a.m. on the date above stated.

(Signature) [illegible]

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Pocatello

Filed July 1 1930 Dr. J. R. Young

Registrar MD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70315

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
Local Registrar's No. 5844
(No.) St Anthony Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Cullen
(a) Residence. No. 320 N. Grant St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): June 12-1930
7. AGE: Years: Still Born; Months; Days; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho
PARENTS
10. NAME OF FATHER: L. M. Cullen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Adalene Talcott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio
14. Informant: L. M. Cullen
(Address): 320 N. Grant
15. Filed 7-1, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 12 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 12 1930 to June 12 1930 that I last saw him alive on June 12, 1930 and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Still born
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Albuminuria of mother
(duration) yrs. 1 mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Brothers M. D.
6-12, 1930 (Address) Pocatello Ida
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: June 12 1930
20. Undertaker: Schumacher & Rosley — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

181864

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 391 206 103 819

RECEIVED JUL 10 1930

County of

City of Pocatello Ida

No. 243 No. 5th St. Ave - Rs.

St Anthony

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 181878

Registration District No. 25 State File No.

Prim. Registration District No. 1 Local Registrar's No. 1

FULL NAME OF CHILD Stillborn Cravey

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? — | and | Number in order of birth — (To be answered only in event of plural births) | Legitimate? Yes | Date of birth June (Month) 6 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% Argyrol

Number of child of this mother, including present birth — (a) Born alive and now living —

Born alive but now dead / Stillborn /

FATHER	MOTHER
FULL NAME Oscar Cravey	FULL MAIDEN NAME Dell Hargrove
Residence (Usual place of abode) 243 No. 5th Ave	Residence (Usual place of abode) 243 No. 5th Ave
If non-resident, give place and State —	If non-resident, give place and State —
Color or race Negro Age at last Birthday 42 (Years)	Color or race Negro Age at last Birthday 38 (Years)
Birthplace Texas (City and State or County)	Birthplace Texas (City and State or County)
Occupation Janitor - O.S.L. Freight House	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 2:25 A. M. on the date above stated.

(Signature) D C Ray

(Physician or ~~midwife~~)

Address Pocatello

Filed July 1930 [illegible] Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10427

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthonys)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5836

2. FULL NAME Infant Cranny
(a) Residence. No. 1243 N. 5th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6, 1930

7. AGE Years — Months — Days — If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER Oscar Cranny
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Delia Hargraves
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Texas

14. Informant Oscar Cranny
(Address)

15. Filed June 6, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Died in Nurses work
cord tied around
arms.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. C. Ray, M. D.
6-6, 1930 (Address)

19. Place of Burial, Cremation, or Removal: Pocatello Ida — Date of Burial June 6 1930

20. Undertaker H. L. McFan — Address Pocatello

12/8/2 + 31/8/2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 10 1930

County of Bannock 551-105

City of Pocatello Ida 003415

No. Arbon Ida Res.

General

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

181881

Registration District No. 28 State File No.

Prim. Registration District No. 161 Local Registrar's No. 9 x 4

FULL NAME OF CHILD Stillborn Evans

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? — | and | Number in order of birth — (To be answered only in event of plural births) | Legitimate? Yes | Date of birth June 5 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? — — — —

Number of child of this mother, including present birth 5 (a) Born alive and now living 2

Born alive but now dead — Stillborn 3

FATHER	MOTHER
FULL NAME Leslie M. Evans	FULL MAIDEN NAME Ella Daniels
Residence (Usual place of abode) Arbon Ida	Residence (Usual place of abode) Arbon, Ida
If non-resident, give place and State —	If non-resident, give place and State —
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 30 (Years)
Birthplace Lynnaria Ida (City and State or County)	Birthplace Malad Ida (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 6:00 P. M. on the date above stated.

(Signature) D C Ray

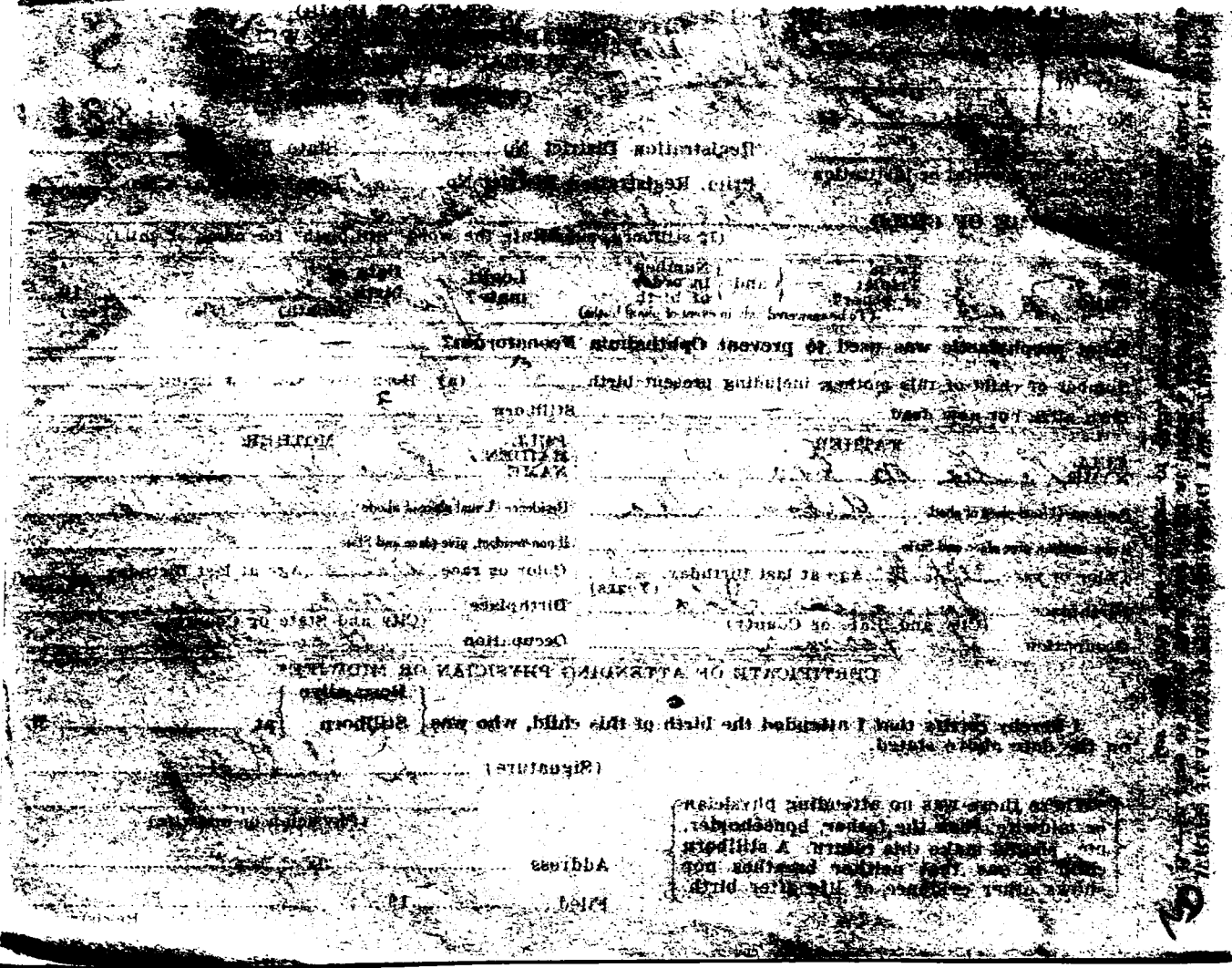
(Physician or midwife)

Address Pocatello

Filed July 19 30 Dr. J. H. Young Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MD



RECEIVED JUL 10 1930

PLACE OF BIRTH

County of Bannock

City of Pocatello

No 055 7107 003473 St.

Lynn Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 181887

Registration District No. 24 State File No.

Prim. Registration District No. 161 Local Registrar's No. 770

FULL NAME OF CHILD Stewart Lee England

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	June 2nd 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Jessie Stewart England	FULL MAIDEN NAME	Aritta Mitchell
Residence (Usual place of abode)	Pocatello Ida	Residence (Usual place of abode)	Pocatello
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	22	Age at last Birthday (Years)	19
Birthplace (City and State or County)	Idaho	Birthplace (City and State or County)	Ammon Ida
Occupation	Coach Cleaner R.R	Occupation	House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 10 M. on the date above stated.

(Signature) [illegible]

(Physician or midwife)

Address Pocatello Idaho

Filed July 1 1930 Dr J K Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20431

Local Registrar's No. 5832

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. Lynn Brothers Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stewart Lee England

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

204

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 2, 1930.

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Jesse England

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Moreland, Idaho.

12. MAIDEN NAME OF MOTHER: Aritta Mitchel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ammon, Idaho.

14. Informant: Jesse England

(Address) 335 North Sixth Ave. Poca., Ida.

15. Filed 6/2/30., 19.... J. R. Young Registrar M.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 2, 1930, that I last saw him alive on June 2, 1930, and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Blue Baby.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? phy Examination

(Signed) J. W. Lynn M. D.

6/2/30., 19.... (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ammon, Idaho. | Date of Burial: 6/3/30. 19

20. Undertaker: Arthur W. Hall | Address: Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bear Lake

City of Georgetown

No. ..... St.

331 110 004 244

(If born in hospital or institution give name.)

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 56 State File No. 181899

Prim. Registration District No. 136 Local Registrar's No. .....

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male			Yes	Jan 10 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 4 Stillborn 1

FATHER		MOTHER	
FULL NAME	Marvin E. Clark	FULL MAIDEN NAME	Alice Budge
Residence (Usual place of abode)	Georgetown Idaho	Residence (Usual place of abode)	Georgetown Ida
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	39	Age at last Birthday (Years)	38
Birthplace (City and State or County)	Utah	Birthplace (City and State or County)	Idaho
Occupation	Farming	Occupation	Page

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 8 P. M. on the date above stated.

(Signature) N. N. Kling M.D.

Physician

(Physician or midwife)

Address Montpelier, Idaho

Filed 6/30/ 1930 N. Kling

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

[illegible]

[illegible]

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70359

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PLACE OF DEATH

County of Bear Lake

City of Georgetown

Registration District No. 52

Primary Registration District No. 2126

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Clark (Stillbirth)

(a) Residence. No. Georgetown Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days — Still Born — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Still-Born Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Georgetown Idaho

PARENTS

10. NAME OF FATHER: Marion E. Clark

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Georgetown Idaho

12. MAIDEN NAME OF MOTHER: Alice Budge

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Paris Idaho

14. Informant: M. E. Clark

(Address): Georgetown Idaho

15. Filed 6/30, 1930 W. W. Kemp Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Instrument of Delivery of Mother (Still Born Child)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Kemp M. D.

6/30, 1930 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Georgetown Ida — Date of Burial: Jan 11 1930

20. Undertaker: Walter Clarke — Address: Georgetown Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 5 1930

PLACE OF BIRTH

County of Bear Lake

City of Montpelier

No. ..... St.

963-208 04-294

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S**

Registration District No. 53 State File No. 181928

Prim. Registration District No. 236 Local Registrar's No. .....

FULL NAME OF CHILD (STILLBORN)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth 5-8 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth One (a) Born alive and now living none

Born alive but now dead none Stillborn none

FATHER	MOTHER
FULL NAME C. W. Roberson	FULL MAIDEN NAME A. Simpson
Residence (Usual place of abode) Montpelier	Residence (Usual place of abode) Montpelier
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 26 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Utah (City and State or Country)	Birthplace Liberty (City and State or Country)
Occupation Salesman	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at ..... M. on the date above stated.

(Signature) Geo F. Conley

(Physician or midwife)

Address Montpelier Ida

Filed 7-30-1930 N. N. Nunn Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Local Registration District No. _____ Local Registrar's No. _____

NAME OF CHILD

(If children, underline the word "twin" or "triplets" or number of child)

Sex of child | Twin, triplet, or number of child (To be completed only in event of twins or triplets) | Date of birth (Month)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. (a) Born alive and now living _____ (b) Born alive but now dead _____

FATHER

Full name _____

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Age at last birthday _____ (Years)

Birthplace _____ (City and State or Country)

MOTHER

Full maiden name _____

Residence (Usual place of abode) _____

If nonresident, give place and State _____

(Color or race) _____ Age at last birthday _____ (Years)

Birthplace _____ (City and State or Country)

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive at _____ (Hour) on the date stated above.

_____ (Signature)

_____ Address

_____ Filed _____ 19__

Where there was no attending physician or midwife, then the father, householder, or other person must give report. If attended by a midwife, the mother, household, or other person must give report of the birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70835

PLACE OF DEATH

County of Bear Lake

City of Montpelier Idaho

Registration District No.

Primary Registration District No. 7 36

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Robinson

(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): 5-8-30

7. AGE: Years 0 Months Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Still-Born Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Montpelier Idaho

PARENTS

10. NAME OF FATHER: Ed. Robinson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Okla.

12. MAIDEN NAME OF MOTHER: Kathryn Simmons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: E. E. Robinson
(Address): Montpelier Idaho

15. Filed 7/30, 1930 N. N. Ray Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,
that I last saw it alive on , 19 ,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cause not known

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Birth

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8-9, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier Idaho — Date of Burial: July 10 1930

20. Undertaker: F. M. Wilson — Address: Montpelier Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) **Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home, and children**, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ~~ascertained~~ as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 7 1930

PLACE OF BIRTH

County of Bingham

City of Pingree

No. ..... St.

386-108-006-649

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S S

CERTIFICATE OF BIRTH

181961

Registration District No. 121 State File No. .....

Prim. Registration District No. 194 Local Registrar's No. 172

FULL NAME OF CHILD Stillborn Thompson

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	June 8 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 9 (a) Born alive and now living 6

Born alive but now dead 1 Stillborn 2

FATHER		MOTHER	
FULL NAME	Floyd Thompson	FULL MAIDEN NAME	Edith Furniss
Residence (Usual place of abode)	Pingree	Residence (Usual place of abode)	Pingree
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	36	Age at last Birthday (Years)	33
Birthplace (City and State or County)	~~Utah~~ Idaho	Birthplace (City and State or County)	Utah
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 5:30 p M. on the date above stated.

(Signature) C W Beck

(Physician or ~~Midwife~~)

Address Blackfoot, Ida.

Filed July 2, 1930 M. Nelson Executive Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70899

PLACE OF DEATH
County of Bingham
City of Pingree, Ida

Registration District No. 121
Primary Registration District No. 2190

Local Registrar's No. 704

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Thompson

(a) Residence. No. Pingree, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 8 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pingree, Idaho

PARENTS

10. NAME OF FATHER Floyd C. Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Blackfoot Idaho
12. MAIDEN NAME OF MOTHER Edith Furniss
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Floyd C. Thompson
(Address) Pingree Ida

15. Filed June 9, 1930 Wm Walton E. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillborn June 8 1930
(Month) (Day) (Year)
~~Had been dead about 10 days~~

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Hydrocephalus

..... (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) W W Beck, M. D.
June 9, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pingree, Idaho — Date of Burial: June 4 1930

20. Undertaker: None — Address: —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine,** etc. Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bellevue

City of Bellevue

No. ..... St.

856 209 007-393

(If born in hospital or institution give name.)

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 181999

Registration District No. 57 State File No. .....

Prim. Registration District No. 2022 Local Registrar's No. 27

FULL NAME OF CHILD STILL BORN Hesselfinger

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
Female				Yes	6	9	1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1 5 months

FATHER	MOTHER
FULL NAME Charles N. Hesselfinger	FULL MAIDEN NAME Myrtle Fay Little
Residence (Usual place of abode) Bellevue, Idaho	Residence (Usual place of abode) Bellevue, Idaho
If nonresident, give place and State	If nonresident, give place and State .....
Color or race White Age at last Birthday 25 (Years)	Color or race White Age at last Birthday 24 (Years)
Birthplace Monroe, Iowa (City and State or Country)	Birthplace Bellevue, Idaho (City and State or Country)
Occupation Ranger	Occupation Home maker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 7 45 P. M. on the date above stated.

(Signature) E. W. Fox

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Hailey, Idaho

Filed 7-1 1930 Robert H. Wright

Registrar.

[illegible]

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70904

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

2. FULL NAME Hoffelfinger

(a) Residence. No. ..... St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Still born 5 mo fetus

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bellevue, Idaho

PARENTS
10. NAME OF FATHER: Charles N. Hoffelfinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine, Germany
12. MAIDEN NAME OF MOTHER: Myrtle Fay Little
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bellevue, Idaho

14. Informant: Mrs Chas Hoffelfinger
(Address): Bellevue, Idaho

15. Filed 7-1, 1930 P. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Still born 5 mo fetus
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. W. Fox, M. D.
6/10, 1930 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bellevue, Idaho — Date of Burial: 6/10 1930
20. Undertaker — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (**secondary** or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from **childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 5 1930

PLACE OF BIRTH

County of Bonner

City of Grouse Creek, Ida

No. 954.109.009.000 St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 76 State File No. 182008

Prim. Registration District No. 2155 Local Registrar's No. 91

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births)

Legitimate? Yes

Date of birth: 6 (Month) 9 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 9 (a) Born alive and now living 7

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME Odell Inman	FULL MAIDEN NAME Minnie
Residence (Usual place of abode) Grouse Creek Ida	Residence (Usual place of abode) Grouse Creek Ida
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 40 (Years)	Color or race White Age at last Birthday 37 (Years)
Birthplace Kansas (City and State or County)	Birthplace Wyoming (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Premature~~ Stillborn at 5.30 p. M. on the date above stated.

(Signature) Wm F. Tyler MD

(Physician or ~~midwife~~)

Address Sandpoint, Idaho

Filed June 3 1930 Stella Allen County Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ Date File No. _____

(Write in ink. Use separate line for each item. Local Registrar's No. _____)

PLACE OF BIRTH

County of _____

City _____

No. _____

(Hospital or institution)

(Street or rural route)

(Full name of child)

(If stillborn, substitute the word "stillbirth" for name of child)

Sex _____ Twin _____ Triplet _____ Quadruplet _____ Quintuplet _____ Sextuplet _____ Birth order _____ (If twin, triplet, etc., state birth order)

Legitimate? _____

Date of birth: (Month) _____ (Day) _____ (Year) _____

Hour _____

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present child: (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

MOTHER

FULL NAME _____

Residence: Last place of abode _____

Residence: Usual place of abode _____

Residence: Street address or location _____

Residence: City or town _____

Residence: County _____

Residence: (City and State or Country) _____

Nationality _____

Occupation _____

Birthplace _____ (City and State or Country)

Color or race _____ Age at last birthday _____ (Years)

FATHER

Residence: Last place of abode _____

Residence: Usual place of abode _____

Residence: Street address or location _____

Residence: City or town _____

Residence: County _____

Residence: (City and State or Country) _____

Nationality _____

Occupation _____

Birthplace _____ (City and State or Country)

Color or race _____ Age at last birthday _____ (Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at the place and time stated above.

(Signature) _____

(Date signed) _____

(Address) _____

Where there was an attending physician or midwife, then the informant, a mother, etc., should make this return. A midwife should in the last matter herein, but always make evidence of the child's birth.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71343

PLACE OF DEATH
County of Bonner
City of Grouse Creek, Ida.

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 53

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Stillborn Inman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9, 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grouse Creek Idaho

PARENTS

10. NAME OF FATHER Elmer Adell Inman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Minnie Bonny
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant Elmer Adell Inman
(Address) Samuels, Idaho

15. Filed June 10, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 9, 1930
that I last saw h..... alive on Stillborn, 19.....
and that death occurred, on the date stated above, at 5:30 P.m.
The CAUSE OF DEATH* was as follows:

Still Birth 8½ month
Foetus. Cause Unknown
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Wm F. Tyler, M. D.
June 10, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal (I.O.O.F.) McArthur Cemetery — Date of Burial June 10 1930

20. Undertaker John + Geo. Berryman — Address Sandpoint, Ida. (rural)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, **as Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. ..... St.

25 1129 010-285

(If born in hospital or institution give name.)

REC'D JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182026

Registration District No. 73 State File No. .....

Prim. Registration District No. 2 1 N 5 Local Registrar's No. 239

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth 4-29-1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol Sol 10%

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Wm. A. Beal	FULL MAIDEN NAME Lucile Boyerly
Residence (Usual place of abode) Idaho Falls	Residence (Usual place of abode) Idaho Falls
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 29 (Years)	Color or race White Age at last Birthday 27 (Years)
Birthplace Idaho Falls (City and State or Country)	Birthplace Idaho Falls (City and State or Country)
Occupation	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / ~~Stillborn~~ } at 3:00 A. M. on the date above stated.

(Signature) [illegible] M.D.

(Physician or midwife)

Address Idaho Falls, Idaho

Filed 4-29, 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 40430

County of Bonneville Registration District No. 73

City of Idaho Falls RR #7, Primary Registration District No. 2146

Local Registrar's No. 79

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME (Still Born) Robert W. Beal.

(a) Residence. No. 6½ miles N. on Montana Highway.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 0 Months 0 Days 0 If LESS than 1 day, 0 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work — None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10 NAME OF FATHER Wm. A. Beal.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo. ~~William A. Beal.~~

12 MAIDEN NAME OF MOTHER Lucy Byerly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mo.

14 Informant Wm. A. Beal.
(Address) R. 7 Idaho Falls. Ida.

15 Filed May 24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 28 (Day) ~~19~~ 30 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw ~~alive~~ Still Born on ..., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Still Born. Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Went Knows.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. J. Sullow M. D.

4/28, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls, Ida.

Date of Burial: 4/28 1930

20. Undertaker: V. F. McHan.

Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**: **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH REGISTERED JUL 10 1930

County of Bonneville
City of Idaho Falls
No. St.
296-116 010-233
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 73 State File No. 182070
Prim. Registration District No. 2 1 3 Local Registrar's No. 260

FULL NAME OF CHILD "Stillbirth" Brothers
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births): | Legitimate? Yes | Date of birth June 16 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 1
Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Ben Brothers	FULL MAIDEN NAME Emma Becker
Residence (Usual place of abode) 286 15th St.	Residence (Usual place of abode) 286 15th St.
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 44 (Years)	Color or race White Age at last Birthday 25 (Years)
Birthplace Venanda Oklahoma (City and State or County)	Birthplace Menno, South Dakota (City and State or County)
Occupation Contractor	Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9:03 P. M. on the date above stated.

(Signature) [illegible]
M.D.
(Physician or midwife)
Address Idaho Falls

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed 6/28 1930 [illegible]
Registrar.

RECEIVED JUL 10 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70944

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 28

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Ida

2. FULL NAME Stillbirth Brothers

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Stillbirth

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16, 1930

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Ben Brothers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wanoole, Oklahoma
12. MAIDEN NAME OF MOTHER Emma Becker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Menno, South Dakota

14. Informant J. H. West
(Address) Idaho Falls Ida

15. Filed 6/10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 16, 1930
that I last saw him alive on June 16, 1930
and that death occurred, on the date stated above, at 8:30 a.m.
The CAUSE OF DEATH* was as follows:

Hemorrhage of mother
(duration) yrs. mos. 1/2 hr ds.
CONTRIBUTORY (Secondary) Placenta Previa
of mother
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Version Date of 6/16/30
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) J. H. West, M. D.
6/17, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Date of Burial: 6/18 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182088

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. 595 101 510 693 St.

L. D. S. Hosp

(If born in hospital or institution give name.)

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. 296

FULL NAME OF CHILD Still Birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male	—			Yes	July 1 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth VII (a). Born alive and now living 4

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Wm J. Nielson	FULL MAIDEN NAME Mary Williams
Residence (Usual place of abode) Idaho Falls Rt #3	Residence (Usual place of abode) Rt #3 Idaho Falls
If non-resident, give place and State —	If non-resident, give place and State
Color or race white Age at last Birthday 38 (Years)	Color or race white Age at last Birthday 38 (Years)
Birthplace Aspen Idah (City and State or County)	Birthplace Rt #3 Idaho Falls Ida (City and State or County)
Occupation Farmer	Occupation None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 2 25 a. M. on the date above stated.

(Signature) J. Grant Mc Ro M.D.

(Physician or midwife)

Address Idaho Falls

Filed June 30 1930 W. Summers

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71357

PLACE OF DEATH
County of Bonneville Co
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-70
Local Registrar's No. 140
(No. 304)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth

(a) Residence. No. Idaho Falls Rt #3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 1, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS

10. NAME OF FATHER: Wm. J. Nielson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hyrum Utah
12. MAIDEN NAME OF MOTHER: Mary Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho Falls Rt #3

14. Informant: Father
(Address): Idaho Falls #3 Rt.

15. Filed 7/9, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 1, 1930
that I last saw him alive on July 1, 1930
and that death occurred, on the date stated above, at 2:35 a.m.
The CAUSE OF DEATH* was as follows:
Prolapsus Cord.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Birth Date of July 1, 1930
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. H. Bird M. D.
July 1, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Date of Burial: July 1930

20. Undertaker: J. A. Bond Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 20 1930

County of Bonneville

City of Idaho Falls

No. ..... St.

244 TD 9 010-251

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182102

Registration District No. 73 State File No. .....

Prim. Registration District No. 215-2 Local Registrar's No. 207

FULL NAME OF CHILD Baby Byungarner (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	5-29-1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? Stillborn

Number of child of this mother, including present birth 1st (a) Born alive and now living none

Born alive but now dead one Stillborn yes — one —

FATHER		MOTHER	
FULL NAME	Lawrence H. Byungarner	FULL MAIDEN NAME	Annie May Beasley
Residence (Usual place of abode)	Shelley	Residence (Usual place of abode)	Shelley Ida
If non-resident, give place and State		If non-resident, give place and State	
Color or race	white Age at last Birthday 22 (Years)	Color or race	white Age at last Birthday 19 (Years)
Birthplace (City and State or County)	Blackfoot Ida	Birthplace (City and State or County)	Shelley Ida
Occupation	Plumber	Occupation	Home keeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 7:36 A.M. on the date above stated.

(Signature) Edwin Cutler M.D.

(Physician or ~~midwife~~)

Address Shelley Ida

Filed May 29 1930 [illegible]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70954

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 110

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Burngarner

(a) Residence. No. Shelley St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Still born

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Still born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Still born
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Idaho Falls

PARENTS

10. NAME OF FATHER: Lawrence Burngarner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Blackfoot Idaho
12. MAIDEN NAME OF MOTHER: Annie May Beasley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Shelley Idaho

14. Informant: Mary Beasley
(Address): Shelley Idaho

15. Filed May 29, 1930. C. Fitzgerald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Unknown (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-29, 1930, to 5-29, 1930
~~that I last saw him alive on ..., 19~~
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Nephritis of Mother.
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary): Pregnancy.
(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death? at home.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory Microscopic
(Signed) Edwin Cutler M. D.
5-29, 1930 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley Cemetery — Date of Burial: 5-29-1930

20. Undertaker: None — Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

249-21-010-466

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 73 State File No. 182110

Prim. Registration District No. 21 Local Registrar's No. 199

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls, Ida.

No. St.

L.D.S. Hospital
(If born in hospital or institution give name.)

FULL NAME OF CHILD Baby Smith
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
female				May 21 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Ben Franklin Smith	FULL MAIDEN NAME Sarah Moore
Residence (Usual place of abode) Rexburg	Residence (Usual place of abode) Rexburg
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 37 (Years)	Color or race white Age at last Birthday 34 (Years)
Birthplace Cedar City, Utah (City and State or Country)	Birthplace Shelton, Idaho (City and State or Country)
Occupation farmer	Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 6:40 P. M. on the date above stated.

(Signature) J. Ray Hatch M.D.
Physician & surgeon
(Physician or midwife)

Address Idaho Falls Idaho

Filed May 22 1930 [illegible]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70926

PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Ida

Registration District No. 23
Primary Registration District No. 2 1 0 0
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 106

2. FULL NAME Baby Smith

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Ben. Franklin Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cedar City, Utah
12. MAIDEN NAME OF MOTHER Sarah Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shelton, Idaho

14. Informant B. F. Smith
(Address) Ririe Idaho

15. Filed May 22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Stillborn - 6 mo. premature
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. Ray Hatch, M. D.
, 19 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cremation | Date of Burial: May 22/30

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

182110 4

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

269706 010 265

RECEIVED JUN 20 1930

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. ..... St.

L.D.S. Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182134

Registration District No. 73 State File No. .....

Prim. Registration District No. 210 Local Registrar's No. 181

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth April 6 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Mr. Phillip C. Borreson	FULL MAIDEN NAME Annie Charlie Iverson
Residence (Usual place of abode) Sh. Anthony	Residence (Usual place of abode) Sh. Anthony Idaho
If non-resident, give place and State	If non-resident, give place and State —
Color or race White Age at last Birthday 43 (Years)	Color or race White Age at last Birthday 40 (Years)
Birthplace Spring City Utah (City and State or County)	Birthplace Mount Pleasant Utah (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was [redacted] Stillborn at 5:45 P.M. on the date above stated.

(Signature) [illegible] M.D.

Physician & Surgeon
(Physician or midwife)

Address Idaho Falls Idaho

Filed May 10 1930 [illegible]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 11061

Registration District No. 73

Primary Registration District No. 2 14 0

Local Registrar's No. 96

(No. L.D.S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

2. FULL NAME Stillborn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year):

7. AGE: Stillborn — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls

PARENTS

10. NAME OF FATHER: Philip C. Borresen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spring City Utah

12. MAIDEN NAME OF MOTHER: Annie Marie Sorensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mount Pleasant Utah

14. Informant: L.D.S. Hospital

(Address): Idaho Falls Idaho

15. Filed May 12, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1930, to Apr 6, 1930

that I last saw him alive on ....., 19....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (duration) ..... yrs. ..... mos. ..... d.

CONTRIBUTORY (Secondary): Placental Edema

..... (duration) ..... yrs. ..... mos. ..... d.

18. Where was disease contracted if not at place of death? St Anthony

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [signature], M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker: none | Address

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18234

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

396 117 010-299

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls, Ida.

No. ..... St.

L.D.S. Hospital

(If born in hospital or institution give name.)

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182142

Registration District No. 73 State File No. .....

Prim. Registration District No. 210 Local Registrar's No. 192

FULL NAME OF CHILD Jennmett Smith Croft

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male				yes	May 17 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Frank Croft	FULL MAIDEN NAME Juanita Smith
Residence (Usual place of abode) 266 Second St.	Residence (Usual place of abode) 266 Second Street
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 27 (Years)
Birthplace Buhl Idaho (City and State or County)	Birthplace Rexburg Idaho (City and State or County)
Occupation Brakeman	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 10:30 a M. on the date above stated.

(Signature) [illegible]

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho Falls Idaho

Filed May 17 1930 [illegible] Registrar.

FORM V. S. No. 6-25 M.-1-30. RECEIVED JUN 20 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 70922
Local Registrar's No. 102

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls, Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 21 V-D
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Croft

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH May (Month) 17 (Day) 1930 (Year)

7. AGE ....Yrs....Mos....ds. Still born

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Falls, Idaho

10. NAME OF Father Frank Croft

11. BIRTHPLACE OF FATHER (State or Country) Basalt Idaho

12. MAIDEN NAME OF MOTHER Juanita Smith

13. BIRTHPLACE OF MOTHER (State or Country) Rexburg Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Clark
(Address) Idaho Falls Ida

15. Filed May 1st 1930 Leo Tomlinson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., **to** ....19...., **that I last saw h.... alive on** ....19...., **and that death occurred on the date stated above, at** ....M.
The CAUSE OF DEATH* was as follows:

Premature birth

....(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary) Did not Know

....(Duration) ....yrs. ....mos. ....ds.

(Signed) C. M. Clark M. D.
....19.... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Greenlawn - Idaho Falls

DATE OF BURIAL May 17 1930

20. UNDERTAKER None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 18242

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

RECEIVED JUL 29 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho JUL 24 1930

182142

Mrs. F. Croft
Idaho Falls

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Jennett Smith Croft.

PLACE OF BIRTH Idaho Falls DATE OF BIRTH May 17, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 2.
3. Born alive but now dead 1
4. Number of children stillborn 2.

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Francis Jennett Croft. (Full name)	Juanita Williams (Full maiden name)
Idaho Falls Idaho. (Residence)	Idaho Falls Idaho (Residence)
Age at last birthday 28	Age at last birthday 27.
Basalt Idaho (Birthplace)	Rexburg Idaho (Birthplace)
O.S.L. Brakeman (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 5 1930

PLACE OF BIRTH

County of Canyon

City of Nampa

No. R. 5 St.

595 204 014 739

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 7 State File No. 182164

Prim. Registration District No. 2006 Local Registrar's No. 130

FULL NAME OF CHILD Fay Lee Vincent

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Fem	Tw	2	Yes	6 - 4 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 10 %

Number of child of this mother, including present birth 10 (a) Born alive and now living 9

Born alive but now dead none Stillborn one

FATHER		MOTHER	
FULL NAME	Jonathan Franklin Vincent	FULL MAIDEN NAME	Tedie Frances Acree
Residence (Usual place of abode)	Nampa R5.	Residence (Usual place of abode)	Nampa R5.
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	57	Age at last Birthday (Years)	37
Birthplace (City and State or Country)	Yard Co. Ark.	Birthplace (City and State or Country)	Caldwell Co. Tex.
Occupation	Laborer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 9 A. M. on the date above stated.

(Signature) J. C. Horton M. D.

(Physician or ~~midwife~~)

Address Nampa Ida.

Filed 6 - 3 1930 [illegible] Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70970

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 72

2. FULL NAME Infant Daughter of J. F. Vincent

(a) Residence. No. 7 1/2 miles N. East of Nampa
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~Single, married, widowed, or Divorced (write the word)~~

5a. ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 4-1930

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: J. F. Vincent
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ark
12. MAIDEN NAME OF MOTHER: Tillie Arney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind

14. Informant: J. F. Vincent
(Address) R#1 Nampa Idaho

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased from~~ on 6-4, 1930, to, 19
that I last saw ~~her~~ alive on, 19
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Still born Due to Shoulder presentation.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Horton, M. D.
6-26, 1930 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem — Date of Burial: 6-5 1930
20. Undertaker: F. W. Robison — Address: Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) **Salesman,** (b) Grocery; (a) Foreman, (b) Automobile **Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. **all diseases resulting from childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

386 101 022 253

PLACE OF BIRTH RECEIVED JUN 23 1930

County of Jerome

City of Jerome

No. St.

St Valentine Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 18 State File No. 182372

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Erwin Dewey Thomason Jr.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male

Twin ~~Triplet~~ or ~~Quadruplet~~ 2 and Number in order of birth (To be answered only in event of plural births) 2

Legitimate? yes

Date of birth April (Month) 1 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 0

FATHER	MOTHER
FULL NAME George Dewey Thomason	FULL MAIDEN NAME Leona L Kelly
Residence (Usual place of abode) Jerome Idaho	Residence (Usual place of abode) Jerome Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 31 (Years)	Color or race white Age at last Birthday 31 (Years)
Birthplace Ark (City and State or County)	Birthplace Ark (City and State or County)
Occupation Farmer	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 9 00 A. M. on the date above stated.

(Signature) Chas H Zeller M.D.

(Physician or midwife)

Address Jerome Idaho

Filed 7/2 1930 Chas H Zeller Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 23 1930

PLACE OF DEATH

County of Jerome

City of Jerome

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71066

Local Registrar's No.

2. FULL NAME Dewey Jr. Thomason

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Apr 1, 1930

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Dewey Thomason

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Lena Kelly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Arkansas.

14. Informant: Dewey Thomason
(Address)

15. Filed 4/1, 1930 Chas F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to April 1st, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Still Born Infant
(Twin) Torsion Cord Intra-Uterine
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. F. Zeller M. D.
4/22, 1931 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Idaho — Date of Burial: Apr 2 1930

20. Undertaker: none — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

182372 N

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 12 1930

PLACE OF BIRTH

County of Latah

City of Moscow

No. RD St.

693-123 D29-216

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182436

Registration District No. 61 State File No.

Prim. Registration District No. 1011 Local Registrar's No. 58

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Male				Yes	June 23 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Victor Wilson	FULL MAIDEN NAME Pearl Dorothy Sawyer
Residence (Usual place of abode) Moscow Idaho	Residence (Usual place of abode) Moscow Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 24 (Years)	Color or race White Age at last Birthday 20 (Years)
Birthplace Washington (City and State or County)	Birthplace Idaho (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } **at** 12:15 P. M. **on the date above stated.**

(Signature) O. J. Armstrong

(Physician ~~or midwife~~)

Address Moscow Idaho

Filed July 9 1930 [illegible]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED JUL 12 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of

Primary Registration District No. 1011

City of

(No. , St.)

File No. 71106

Registered No. 126

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*)

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Victor Wilson

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Pearl Dorothy Sawyer

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed July 9 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 23 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1930, to June 23 1930 that I last saw h... alive on 191..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Stillborn

Premature

(Duration) yrs. mos. ds.

Contributory (Secondary) Not Known

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

6/ 19 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 191...

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18246 ×

SYMS - YORK CO., PTRS. & BDRS. 19760

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility, ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

66 6010-029-693

PLACE OF BIRTH

RECEIVED JUN 23 1930

County of Latah

City of Moscow

No. East D" St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182457

Registration District No. 61 State File No.

Prim. Registration District No. 1011 Local Registrar's No. 39

FULL NAME OF CHILD Premature 4 months Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Undetermined	(To be answered only in event of plural births)			Yes	May 10, 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Frank H. Woolf	FULL MAIDEN NAME Helen Williams
Residence (Usual place of abode) Moscow Idaho	Residence (Usual place of abode) Moscow Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 29 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Canada (City and State or County)	Birthplace Idaho (City and State or County)
Occupation Laborer	Occupation Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 2:30 P. M. on the date above stated.

(Signature) Chas. L. Fritman

(Physician ~~or midwife~~)

Address Moscow Idaho

Filed 6/19 1930 Dan Greenhouse

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

314-006-035-719

RECEIVED JUL 10 1930

PLACE OF BIRTH

County of Nez Perce

City of Lewiston

No. St. Joseph St.

(If born in hospital or institution give name)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 182549

Registration District No. 96 State File No.

Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
✓				yes	6		1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead ✓ Stillborn 1 ✓

FATHER		MOTHER	
FULL NAME	Lester L. Campbell	FULL MAIDEN NAME	Francis Parsons
Residence (Usual place of abode)	Lewiston	Residence (Usual place of abode)	Lewiston
If nonresident, give place and State		If nonresident, give place and State	Idaho
Color or race	White	Color or race	White
Age at last Birthday	19 (Years)	Age at last Birthday	19 (Years)
Birthplace (City and State or Country)	Wn	Birthplace (City and State or Country)	Wash
Occupation	Lumberman	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 4:25 M. on the date above stated.

(Signature) O. C. Carson

Lewiston Ida

(Physician or midwife)

Address

Filed 7-7 1930 J. M. Lyle

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

Local Registrar's No.

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Leon G. Campbell.

(a) Residence. No. 157 - 7th Street St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 5/6/30

7. AGE: Years | Months | Days: Premature | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho.

PARENTS

10. NAME OF FATHER: Lester Campbell

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Francis Parsons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wash.

14. Informant: Lester Campbell

(Address): Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6th, 1930, to May 6th, 1930 that I last saw him alive on May 6th, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxemia of mother

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible], M. D.

[illegible], 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nalla Nalla Wash — Date of Burial: 5/9 1930

20. Undertaker: Vassar Mortuary — Address: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

265 222-035 296

PLACE OF BIRTH

RECEIVED JUL 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce

City of Lewiston Orchards.

No. ..... St. Registration District No. 96 File No. 182572

Hospital ..... Primary Registration District No. 1009 Registered No. .....

FULL NAME OF CHILD Virginia Sweet

(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
F				yes	4-22-30

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	Harold Sweet	FULL MAIDEN NAME	Issie Brown
RESIDENCE	Lewiston Orchards, Ida.	RESIDENCE	Lewiston Orchards, Ida.
COLOR	W	COLOR	W
AGE AT LAST BIRTHDAY (Years)	30	AGE AT LAST BIRTHDAY (Years)	30
BIRTHPLACE	Washington	BIRTHPLACE	Oklahoma.
OCCUPATION	Laborer	OCCUPATION	Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born (~~Born alive~~ or stillborn), at 12 30 p. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. Rouse M.D.

(Physician or midwife)

Address Lewiston, Idaho

Filed 7-10 1930. J. M. Lyle

Registrar.

Give names added from a supplemental report.

....., 192.....

.....

Registrar.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. .....

Registration District No. 9586

Primary Registration District No. 1009

Local Registrar's No. .....

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

-PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

2. FULL NAME Virginia Sweet.

(a) Residence. No. ..... St. Orchards.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 22nd, 1930.

7. AGE Years ----- Months ----- Days ---- If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, I
(State or country) Idaho.

PARENTS

10. NAME OF FATHER H. R. Sweet.

11. BIRTHPLACE OF FATHER (city or town) Seattle,
(State or Country) Washington.

12. MAIDEN NAME OF MOTHER Iesie Mae Brown.

13. BIRTHPLACE OF MOTHER (city or town) Oklahoma.
(State or Country)

14. Informant O. R. Sweet.
(Address) Lewiston, Idaho.

15. Filed Jun 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22nd, 1930. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/22-30, 19.., to 4/22-30, 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Still born.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Rowe, M. D.

4/23/30, 19.. (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 4/23/30. 19

20. Undertaker: Brower-Vann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18-572 A

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Do not accept a certificate of death signed only by a midwife.

445 124 035 261

PLACE OF BIRTH

RECEIVED JUL 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce

City of Lewiston

No. ..... St.

Registration District No. 96 File No. 182573

Hospital ..... Primary Registration District No. 1009 Registered No. .....

FULL NAME OF CHILD Baby Mundell

(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
M				Yes	4-24-30 192....

What bactericidal solution was used in eyes? 20% Argyrol

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	Geo. E. Mundell	FULL MAIDEN NAME	Verna Swarty
RESIDENCE	Lewiston, Ida.	RESIDENCE	Lewiston, Ida.
COLOR	W	COLOR	W
AGE AT LAST BIRTHDAY	22 (Years)	AGE AT LAST BIRTHDAY	18 (Years)
BIRTHPLACE	Colo.	BIRTHPLACE	Colo.
OCCUPATION	Salesman.	OCCUPATION	Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ..... (Born alive or stillborn) at ..... M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. L. White M.D.

(Physician or midwife)

Address Lewiston Ida

Give names added from a supplemental report.

....., 192....

....
Registrar.

Filed 7-10 192 30 [illegible]
Registrar.

Roman

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 9596

Primary Registration District No. 1009

Local Registrar's No.

(No. 2203 8th, Ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jesse Walter Mundell.

(a) Residence. No. 2203 8th, Ave. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male..

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 24th, 1930.

7. AGE: Years ---- Months ---- Days ---- If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, (State or country) Idaho.

PARENTS

10. NAME OF FATHER L. E. Mundell.

11. BIRTHPLACE OF FATHER (city or town) Hugo, (State or Country) Colorado.

12. MAIDEN NAME OF MOTHER Verna Swartz.

13. BIRTHPLACE OF MOTHER (city or town) Boulder, (State or Country) Colorado.

14. Informant J. W. Mundell.

(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930. Frank E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24th, 1930. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/24-30, 19, to 4/24-30, 19

that I last saw h alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Negro

(Signed) H. Bruce M.D., M. D.

4/24/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho.

Date of Burial: 4/25/30. 19

20. Undertaker: Brower-Vann Compa[illegible]

Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 8 1930

PLACE OF BIRTH

County of Nez Perce

City of Southwick

No. ..... St.

386-105-035-314

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182586

Registration District No. 63 State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD No Name Still Born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth

Legitimate? Yes

Date of birth 6 . 5th, 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None needed

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead None Stillborn One

FATHER	MOTHER
FULL NAME Arthur Thornton	FULL MAIDEN NAME Helen Lamb
Residence (Usual place of abode) Southwick Idaho	Residence (Usual place of abode) Southwick Idaho
If nonresident, give place and State —	If nonresident, give place and State —
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 30 (Years)
Birthplace Joel Idaho (City and State or Country)	Birthplace England (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 6 — P — M. on the date above stated.

(Signature) Russell Truitt
Physician
(Physician or midwife)

Address Southwick Idaho

Filed June 8 1930 B. F. Nesbit
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71124

PLACE OF DEATH
County of Nez Perce
City of Southwick

Registration District No.
Primary Registration District No. 63
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME None Still Born about 7 mos in utero

(a) Residence. No. Southwick Idy St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Neither

6. DATE OF BIRTH (month, day and year)

7. AGE 0 Years | Months 0 | Days 0 | If LESS than 1 day, 0 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Southwick Idy

PARENTS
10. NAME OF FATHER Arthur Thornton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Juel Idy
12. MAIDEN NAME OF MOTHER Helen Lamb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Arthur Thornton
(Address) Southwick Idy

15. Filed June 5, 1930 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 4, 1930
that I last saw him alive on dead on Arrival, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
died in utero
Still Born
(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) None
(duration) 1 yrs. 1 mos. 1 ds.

18. Where was disease contracted if not at place of death? not known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Russell Pruitt, M. D.
June 4th, 1930 (Address) Southwick Idy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Southwick Cemetery — Date of Burial June 5 1930
20. Undertaker None — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18-5 86 7

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, **Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as **"PUERPERAL septicemia," "PUERPERAL peritonitis,"** etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. 212-223-042-019 St.

T F Co & General Hosp

(If born in hospital or institution give name.)

JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 182702

Registration District No. 37 State File No.

Prim. Registration District No. 2085 Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	June 23 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Robert Caldwell Basford	FULL MAIDEN NAME	Florence Farmer
Residence (Usual place of abode)	Filer RI	Residence (Usual place of abode)	Filer, RI
If nonresident, give place and State	Idaho	If nonresident, give place and State	
Color or race	W	Color or race	W
Age at last Birthday (Years)	21	Age at last Birthday (Years)	17
Birthplace (City and State or Country)	Kan	Birthplace (City and State or Country)	Wingo Idaho
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 3:50 a M. on the date above stated.

(Signature) G. A. Dwyer M.D.

(Physician or midwife)

Address Filer, Ida

Filed July 9 1930 Elizabeth J. Smith Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

nOD

344-007-001-466

RECEIVED AUG 7 1930

PLACE OF BIRTH

County of Ada

City of Meridian

No. R 3 St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 11 State File No. **182791**

Prim. Registration District No. 2003 Local Registrar's No. 26

FULL NAME OF CHILD Baby Summers (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
				Yes	7 7 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead ..... Stillborn .....

FATHER	MOTHER
FULL NAME Chas. E. Summers	FULL MAIDEN NAME Dora Moore
Residence (Usual place of abode) Meridian R 3	Residence (Usual place of abode) Meridian R 3
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday 38 (Years)
Birthplace Harrison Arkansas (City and State or County)	Birthplace Harrison Arkansas (City and State or County)
Occupation Farmer	Occupation At home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} **at** 5-30 a. **M. on the date above stated.**

(Signature) J. F. Neal

(Physician or midwife)

Address Meridian Idaho

Filed 8-1 1930 J. F. Neal

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECO
N. B.—In case of more than one child at birth a SEPARATE RETURN must be
for each and the number of each, in order of birth stated.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ Registration Number _____

Place of birth: County _____ City _____ Hospital _____

Full Registration District No. _____ Local Registrar's No. _____

NAME OF CHILD _____

(If stillborn, substitute the word "stillbirth" for name of child)

Sex _____ Color or race _____ Single, twin, triplet, etc. _____ Birth order _____

Date of birth: (Month) _____ (Day) _____ (Year) _____ 19__

Other pregnancies ever used to prevent Quickening Miscarriage _____

FATHER

Full name _____

Color or race _____ Age at last birthday _____ (Years)

Birthplace (City and state or country) _____

Occupation _____

MOTHER

Maiden name _____

Color or race _____ Age at last birthday _____ (Years)

Birthplace (City and state or country) _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Date _____

Where there was no attending physician or midwife, then the father, householder, etc., should make this report. A stillborn child is one that neither breathes nor shows other evidence of life.

RECEIVED AUG 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71293

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

204

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meridian Idaho

PARENTS
10. NAME OF FATHER: Charles E Summers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Arkansas
12. MAIDEN NAME OF MOTHER: Dora Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Arkansas

14. Informant: Elos E Summers
(Address): Meridian Id R. 3

15. Filed 7-8, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-7-30, 19, to 7-7, 1930
that I last saw h[illegible] on 7-7, 1930
and that death occurred, on the date stated above, at 5:20 m.

The CAUSE OF DEATH* was as follows: Still Born due to injury to placenta which was only half normal size

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) N. F. Neal, M. D.
7-7, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: July 7 1930

20. Undertaker: N S Mathes — Address: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 6 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho AUG 22 1930

Mrs. C.E. Summers
Meridian

182791

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Baby.

PLACE OF BIRTH Meridian DATE OF BIRTH July 7, 1930 SEX OF CHILD ?

1. Number of children born to this mother, including present birth 7
2. Number born alive and now living 6
3. Born alive but now dead
4. Number of children stillborn 1

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Charlie E. Summers (Full name)	Dora Summers. (Full maiden name)
meridian (Residence)	meridian (Residence)
Age at last birthday 39	Age at last birthday 38
arkansas (Birthplace)	arkansas (Birthplace)
farming (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

517-122009-793

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

182985

PLACE OF BIRTH

County of Bonner

City of Sandpoint, Ida.

No. ..... St. Parnell Hospital

(If born in hospital or institution give name.)

Registration District No. 74 State File No. .....

Prim. Registration District No. 2155 Local Registrar's No. 106

FULL NAME OF CHILD Stillborn Eagan

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Male				Yes	July 22 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead ..... Stillborn 1

FATHER		MOTHER	
FULL NAME	Fitz W. Eagan	FULL MAIDEN NAME	Era M. Gilroy
Residence (Usual place of abode)	Hope, Ida.	Residence (Usual place of abode)	Hope, Ida
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)		Age at last Birthday (Years)	
Birthplace (City and State or County)	Cheney, Wash.	Birthplace (City and State or County)	Colorado
Occupation	Rancher	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn **at** 11:30 P. M. **on the date above stated.**

(Signature) Floyd G. Wendle M.D.

(Physician or midwife)

Address Sandpoint, Idaho

Filed Aug 4 1930 Viola Allen Deputy Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

(Title. Registration District No. ..... Local Registration No. .....

(If stillborn, substitute the word "stillborn" for name of child)

Sex of child	Twin, triplet, or other plurality	Number in order of birth	Legitimate or illegitimate	Date of birth (Month)	(Day)	(Year)

(To be completed only in case of twins, triplets, etc.)

Number of children now living, including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER

Full name ..... Color or race ..... Age at last birthday (Years) .....

Birthplace (City and State or Country) .....

Occupation ..... Industry .....

Residence (Last place of abode) .....

(Street or rural route, city or town, county and state)

MOTHER

Full name ..... Color or race ..... Age at last birthday (Years) .....

Birthplace (City and State or Country) .....

Occupation ..... Industry .....

Residence (Last place of abode) .....

(Street or rural route, city or town, county and state)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at ..... on the date above stated.

(Signature) .....

(Address) .....

(Position or title) .....

Filed ..... (Registrar)

Where there was no attending physician or midwife then the father, householder, or other person must make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71319

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Infant Eagan.

(a) Residence. No. Hope, Ida (rural) St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 22, 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sandpoint Idaho

PARENTS
10. NAME OF FATHER: Fitz W. Eagan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cheney Wash.
12. MAIDEN NAME OF MOTHER: Eva M. Gilroy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colo.

14. Informant: Fitz Eagan
(Address): Hope, Ida

15. Filed July 23, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 22 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 22, 1930
that I last saw h[illegible] alive on Stillborn, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Prolonged and difficult forceps delivery.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Floyd C. Wendle M.D.
July 23, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: July 23 1930
20. Undertaker: L. G. Mann — Address: Sandpoint Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from **childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

766-121-010-386

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. ..... St. Spencer Hospital

(If born in hospital or institution give name.)

AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183007

Registration District No. 73 State File No. .....

Prim. Registration District No. 2-1-76 Local Registrar's No. 314

FULL NAME OF CHILD Perry Powell

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? 1 | and | Number in order of birth 3 (To be answered only in event of plural births) | Legitimate? yes | Date of birth June 21 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Isaac Newton Powell	FULL MAIDEN NAME Francis Thomas
Residence (Usual place of abode) Jackson	Residence (Usual place of abode) Jackson
If non-resident, give place and State Wyom	If non-resident, give place and State Wyom
Color or race White Age at last Birthday 32 (Years)	Color or race White Age at last Birthday 34 (Years)
Birthplace Jordan Valley Oregon (City and State or County)	Birthplace Cincinnati Ohio (City and State or County)
Occupation rancher	Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 3 35 a. M. on the date above stated.

(Signature) [illegible]

(Physician ~~or midwife~~)

Address Idaho Falls, Ida

Filed July 18 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED SEP 8 1930

DIVISION OF VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho AUG 23 1930

183007

Mrs. I.N. Powell
Jackson, Wyoming

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Perry Powell

PLACE OF BIRTH Idaho Falls, Idaho DATE OF BIRTH June 21, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 3
2. Number born alive and now living 1
3. Born alive but now dead 1
4. Number of children stillborn 1

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Isaac Newton Powell (Full name)	Frances Wellborn Thomas (Full maiden name)
Jackson, Wyo (Residence)	Jackson, Wyo. (Residence)
Age at last birthday 34	Age at last birthday 32
Walla Walla, Wash. (Birthplace)	Selma, Ala. (Birthplace)
Rancher & Cattle-Man (Occupation)	(High School Teacher)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Macey

C.K. Macey
Special Agent, Bureau of the Census.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC [illegible]
BUREAU OF VITAL [illegible]

PLACE OF B[illegible]

City or [illegible]

No. [illegible] St.

(If born in hospital or institution give name.)

CERTIFICATE OF [illegible]

Registration District No. 73 State File No. [illegible]

Prim. Registration District No. 2170 Local Registrar's No. 32 183014

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	July 15 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn 2

FATHER	MOTHER
FULL NAME Mark Wilson	FULL MAIDEN NAME Estella Maughan
Residence (Usual place of abode) 520 N. Water, City	Residence (Usual place of abode) 520 N. Water, City
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday 38 (Years)
Birthplace Riverton Utah (City and State or County)	Birthplace Weston, Idaho (City and State or County)
Occupation Potato Inspector	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 1125 A.M. on the date above stated.

(Signature) [illegible] M.D.

(Physician or midwife)

Address Rigby Idaho

Filed 7/30 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72328

Local Registrar's No. 190

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2170

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Silcox

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 15 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) L. D. S. Hospital

PARENTS

10. NAME OF FATHER Mark Silcox

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston, Utah

12. MAIDEN NAME OF MOTHER Edith Monghan

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Weston, Ida

14. Informant .....
(Address) .....

15. Filed Oct 3, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 15, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 15, 1930, that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cremation.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What ~~test confirmed diagnosis~~? .....

(Signed) T. R. Hart, M. D.

July 16, 1930 (Address) Ogden

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Death Dell Ch. | Date of Burial 19

20. Undertaker: [illegible] | Address —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED AUG 12 1930

PLACE OF BIRTH

County of Canyon

City of Caldwell

No. 386 129.01K-313 St.

Memorial Park Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 183051

Registration District No. 3 State File No.

Prim. Registration District No. 2005 Local Registrar's No. 134

FULL NAME OF CHILD Everett Ira Thompson

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child M | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth July (Month) 29 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME James Thompson	FULL MAIDEN NAME Vera Galloway
Residence (Usual place of abode) Caldwell Ida	Residence (Usual place of abode) Caldwell
If nonresident, give place and State —	If nonresident, give place and State —
Color or race W Age at last Birthday 24 (Years)	Color or race W Age at last Birthday 21 (Years)
Birthplace Nebraska (City and State or Country)	Birthplace Nebraska (City and State or Country)
Occupation farmer	Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive / Stillborn at 10 a M. on the date above stated.

(Signature) M Montgomery MD

(Physician or ~~midwife~~)

Address Caldwell Ida

Filed 7-30-1930 John S. Meyer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71373

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 91
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Everett Ira Thompson

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Still born.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell, Idaho

PARENTS

10. NAME OF FATHER James Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Vera Gallaway
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Nebraska

14. Informant James Thompson
(Address) Huston, Idaho Rt #2

15. Filed 7-30-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930 to July 29, 1930
that I last saw him alive on July 29, 1930
and that death occurred, on the date stated above, at 10 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no test
(Signed) M. Montgomery, M. D.
7/29, 1930 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 7-30-1930

20. Undertaker: Paul L. Case — Address: Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

615-186-028-655

PLACE OF BIRTH

County of Kootenai

City of Coeur d'Alene

No. 412 Lakeside St.

Lakeside Hosp.

(If born in hospital or institution give name.)

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 30 State File No. 183227

Prim. Registration District No. 105-0 Local Registrar's No. 118

FULL NAME OF CHILD Melvin LeRoy Wang

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births)

Legitimate? Yes

Date of birth: 4 - 6 - 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME: Ludwig Wang	FULL MAIDEN NAME: Millie Overby
Residence (Usual place of abode): Coeur d'Alene Ida	Residence (Usual place of abode): Coeur d'Alene Ida
If non-resident, give place and State:	If non-resident, give place and State:
Color or race: W Age at last Birthday: 41 (Years)	Color or race: W Age at last Birthday: 39 (Years)
Birthplace: Norway (City and State or County)	Birthplace: Cooperstown N.D. (City and State or County)
Occupation: Carpenter	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 10:30 P. M. on the date above stated.

(Signature) Harold J. Sturgis M.D.

(Physician or midwife)

Address Coeur d'Alene Ida.

Filed 7/29 1930 H. J. Sturgis Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

[illegible]

[illegible]

RECEIVED AUG 11 1930

71436

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71280~~

Local Registrar's No. 91

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No.

Primary Registration District No.

(No. Lakeside Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2011

2. FULL NAME Melvin LeRoy Wang

(a) Residence. No. 1004 - 4th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930-7-6

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, 0 hrs. or 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER Ludvig Wang

11. BIRTHPLACE OF FATHER (city or town) Norway
(State or Country)

12. MAIDEN NAME OF MOTHER Millie Overby

13. BIRTHPLACE OF MOTHER (city or town) Cooperstown
(State or Country) N.D.

14. Informant Ludvig Wang
(Address) Coeur d'Alene

15. Filed 7-11, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~May~~, 19~~30~~, to ~~July~~, 1930 that I last saw her alive on ~~July 6~~, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Difficult + prolonged labor
Still born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) Harold J. Stringer, M. D.

7-7, 1930 (Address) Ola Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Conrad Cem Kalispell Mt. | Date of Burial: 7-9 1930

20. Undertaker: Cassedy Funeral Home | Address: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED AUG 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

PLACE OF BIRTH
County of Lemhi
City of Salmon
No. ..... St.
795-106-030-236
(If born in hospital or institution give name.)

Registration District No. 41 State File No. 183257
Prim. Registration District No. 2116 Local Registrar's No. .....

FULL NAME OF CHILD Stillbirth (6 mont)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth June 6 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 3 (a) Born alive and now living 2
Born alive but now dead ..... Stillborn .....

FATHER
FULL NAME Ted Greg
Residence (Usual place of abode) Mackay
If nonresident, give place and State .....
Color or race Wh Age at last Birthday 26 (Years)
Birthplace Idaho (City and State or Country)
Occupation Miner

MOTHER
FULL MAIDEN NAME Lue Blood
Residence (Usual place of abode) Mackay
If nonresident, give place and State .....
Color or race Wh Age at last Birthday 22 (Years)
Birthplace Idaho (City and State or Country)
Occupation Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born ~~alive~~ / Stillborn } at 8 a M. on the date above stated.

(Signature) J S Wright MD
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Salmon

Filed ..... 19..... .....
Registrar.

MD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Shoshone

City of Kellogg, Idaho

No. ..... St.

315-208-032-243

(If born in hospital or institution give name.)

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 183271

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. 34

FULL NAME OF CHILD Baby — No name. Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	Aug 8 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 9 (a) Born alive and now living 4

Born alive but now dead ..... Stillborn .....

FATHER		MOTHER	
FULL NAME	Lester Cayenne	FULL MAIDEN NAME	Violet Butler
Residence (Usual place of abode)	Shoshone	Residence (Usual place of abode)	Shoshone
If nonresident, give place and State	Idaho	If nonresident, give place and State	Idaho
Color or race	White	Color or race	White
Age at last Birthday	37 (Years)	Age at last Birthday	33 (Years)
Birthplace (City and State or Country)	Colo	Birthplace (City and State or Country)	Idaho
Occupation	Drayman	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 2 P M. on the date above stated.

(Signature) .....

F. L. Dell MD

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address .....

Filed Aug 4 1930 J. L. Treller

Registrar.

386-120-038-4455

RECEIVED AUG 5 1930

PLACE OF BIRTH

County of Twin

City of Twin Falls

No. ..... St.

Bethany

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183356

Registration District No. 25 State File No. .....

Prim. Registration District No. 2072 Local Registrar's No. 52

FULL NAME OF CHILD Davie Lee Thompson

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
Male				Yes	July	20	1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? Ag. Nit. 3

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn one (Ectampria)

FATHER		MOTHER	
FULL NAME	Leo G Thompson	FULL MAIDEN NAME	Agnes Davis
Residence (Usual place of abode)	Twin Falls	Residence (Usual place of abode)	Twin Falls
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	27	Age at last Birthday (Years)	28
Birthplace (City and State or County)	Mo	Birthplace (City and State or County)	Ore
Occupation	Clerk	Occupation	Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at — M. on the date above stated.

(Signature) A F Schultz M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address .....

Filed Aug 2 1930 Genevieve Nolt Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71491

PLACE OF DEATH

County of Power

City of American Falls

CERTIFICATE OF DEATH

Registration District No. 33

Primary Registration District No. 2079

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 17

2. FULL NAME (Still Birth)

(a) Residence. No. American Falls Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year)

7 AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) American Falls

PARENTS

10 NAME OF FATHER Leo G Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo.

12 MAIDEN NAME OF MOTHER Agnes Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ore.

14 Informant Leo G Thompson
(Address)

15 Filed Aug 4, 1930 Genevieve Nolte Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930 to , 19 ,
that I last saw h alive on , 19 ,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Mitral valve endocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. F. Schick, M. D.
7/21, 1930 (Address) American Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

18356 N

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

RECEIVED SEP 3 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho AUG 23 1930

183356

Mrs. L.G. Thompson
American Falls

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Davis Lee, Thompson.

PLACE OF BIRTH American Falls DATE OF BIRTH July 20, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 4
3. Born alive but now dead
4. Number of children stillborn I

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Lee Golden Thompson	Agnes Irene Davis.
(Full name)	(Full maiden name)
American Falls Idaho.	American Falls Idaho.
(Residence)	(Residence)
Age at last birthday 37	Age at last birthday 28
Memphis Mo.	Spray Oregon.
(Birthplace)	(Birthplace)
(Occupation)	Engineer.

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Macey

C.K. Macey
Special Agent, Bureau of the Census.

299-108 842 319

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. ..... St.

J.F. Co Hospital

(If born in hospital or institution give name.)

REGISTERED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 37 State File No. 183384

Prim. Registration District No. 2085 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: M

Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth

Legitimate? Yes

Date of birth July (Month) 8 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Harry A. Brizee	FULL MAIDEN NAME Lucille Carturight
Residence (Usual place of abode) Twin Falls	Residence (Usual place of abode) Twin Falls
If nonresident, give place and State	If nonresident, give place and State .....
Color or race W Age at last Birthday 47 (Years)	Color or race W Age at last Birthday 28 (Years)
Birthplace Watertown S. Dak (City and State or Country)	Birthplace Ely Nebraska (City and State or Country)
Occupation	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / Stillborn at 4:30 P M. on the date above stated.

(Signature) J. M. Davis

(Physician ~~or midwife~~)

Address Kimberly Idaho

Filed August 6th 1930 Elizabeth J. Smith

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 14 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71507

Registered No.

1. PLACE OF DEATH.

County of Twin Falls

City of ... 11 - 1-1

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 10855

(No. Co. Twin Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Bryce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 7 (Day) 1930 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER H. A. Bryce

11. BIRTHPLACE OF FATHER (State or Country) So. Dakota

12. MAIDEN NAME OF MOTHER Margret Cortwright

13. BIRTHPLACE OF MOTHER (State or Country) Nev.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. A. Bryce

(Address) Twin Falls

15.

Filed August 6th 1930 Elizabeth J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1930, to July 7 1930, that I last saw him alive on July 7 1930, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Maternal Toxemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Davis M. D.

7/7 1930 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: July 10 1930

20. UNDERTAKER: J. Thorburn & Son

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 24658

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH AUG 4 1980

County of Twin Falls

City of Buhl

No. R. R. St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

18342

Registration District No. 39 State File No.

Prim. Registration District No. 2087 Local Registrar's No.

FULL NAME OF CHILD Un Named.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child boy | Twin Triplet or other? One (To be answered only in event of plural births) | and Number in order of birth 6 | Legitimate? yes | Date of birth June 16 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Crede

Number of child of this mother, including present birth 6 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 3

FATHER	MOTHER
FULL NAME Joe Baxter	FULL MAIDEN NAME Elsie Dix
Residence (Usual place of abode) Buhl Ida	Residence (Usual place of abode) Buhl Ida
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 45 (Years)	Color or race White Age at last Birthday 40 (Years)
Birthplace Kansas (City and State or Country)	Birthplace Kansas (City and State or Country)
Occupation farmer	Occupation Home Worker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 4 30 a M. on the date above stated.

(Signature) R E Lantz

(Physician or midwife)

Address Buhl Ida

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed 7-5 1930 J. T. Wheatley Registrar.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... Form Reg. Registration District No. ..... Local Reg. No. .....

(If born in hospital or institution give name.)

County of .....

City of .....

St. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child	Triplet or order of birth	Number in order of birth	Stillbirth?	Date of birth	Hour (Day)

(To be answered only in event of twins in that)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth ..... Born alive and now living .....

Born alive but now dead .....

FATHER	MOTHER
Full name	Full name .....
Residence (usual place of abode)	Residence (Usual place of abode) .....
If nonresident, give place and State	If nonresident, give place and State .....
Color or race ..... Age at last birthday ..... (Years)	Color or race ..... Age at last birthday ..... (Years)
Birthplace (City and State or Country)	Birthplace (City and State or Country) .....
Occupation	Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at ..... M. on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19..

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71194

PLACE OF DEATH

County of Twin Falls

City of Buhl

Registration District No. 39

Primary Registration District No. 2087

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Dean Baxter

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): June 16 1930

7. AGE: Years — Months — Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Buhl Idaho

PARENTS

10. NAME OF FATHER: Joe Baxter

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Elsie Dix

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: J W Campbell
(Address): Buhl Idaho

15. Filed 6-16, 1930. J. H. Murphey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 16th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 to June, 19

that I last saw h alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pre natal death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Extreme Obesity of mother

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R E Smith, M. D.

, 19 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Cemetery — Date of Burial: 6/16 1930

20. Undertaker: Wells & Sons — Address: Buhl Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull,** and consequences (e. g. **sepsis,** tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. St. Anthony St.

Hosp.

(If born in hospital or institution give name.)

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183589

Registration District No. 28 State File No.

Prim. Registration District No. 161 Local Registrar's No. 9944

FULL NAME OF CHILD — Stillbirth — Walker.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				yes	8 - 15 - 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME Ray H Walker	FULL MAIDEN NAME Freda Schmid
Residence (Usual place of abode) 1045 E Fremont	Residence (Usual place of abode) 1045 E. Fremont
If non-resident, give place and State	If non-resident, give place and State
Color or race Wh Age at last Birthday 38 (Years)	Color or race Wh Age at last Birthday 38 (Years)
Birthplace Kansas City Missouri (City and State or County)	Birthplace Paris Idaho (City and State or County)
Occupation Engineer	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } **at** 10 45 **P. M. on the date above stated.**

(Signature) [illegible]

(Physician or ~~midwife~~)

Address Pocatello

Filed 9-1 1930 J R Young H C Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7156

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5883

206

2. FULL NAME Nettie Ann Walker

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 15, 1930.

7. AGE: Years: Still-born; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Ray H. Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas, Missouri.
12. MAIDEN NAME OF MOTHER: Feda Schmid
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Paris, Idaho.

14. Informant: Ray H. Walker
(Address) 1045 East Freman St. Poca., Ida.

15. Filed 8/16/30. 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 15, 1930. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-15, 1930, to 8-15, 1930
that I last saw h— alive on —, 19..
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Still-birth due to pre-partum hemorrhage
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
8/16/30. 19.. (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery, Pocatello, Idaho.
Date of Burial: 8/16/30. 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a **definite** disease can be ascertained as the cause. Always **qualify** as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

212-225-006-464

RECEIVED SEP 3 1930

PLACE OF BIRTH

County of Bingham

City of Pingree

No. ..... St.

Beck Hospital (If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183632

Registration District No. 121 State File No. .....

Prim. Registration District No. 107 Local Registrar's No. 267

FULL NAME OF CHILD Stillborn Baker

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? (To be answered only in event of plural births) | and | Number in order of birth | **Legitimate?** Yes | **Date of birth** Aug 25 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Raymond E. Baker	FULL MAIDEN NAME Grace Mae Dodge
Residence (Usual place of abode) Pingree	Residence (Usual place of abode) Pingree
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 32 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Missouri (City and State or County)	Birthplace Idaho (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Respirative~~ **Stillborn** } **at** 4:30 A **M. on the date above stated.**

(Signature) W W Beck

(Physician or ~~midwife~~)

Address Blackfoot, Idaho

Filed Sept. 4 1930 Mrs Valerie Cabrie

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

[illegible]

[illegible]

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7163

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 138

2. FULL NAME Stillborn Baker

(a) Residence. No. Pingree Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 25, 1930

7. AGE: Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.
Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Ida

PARENTS

10. NAME OF FATHER Raymond E. Baker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lamar Missouri
12. MAIDEN NAME OF MOTHER Grace Mae Dodge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Raymond E. Baker
(Address) R. Pingree Idaho

15. Filed Sep 2, 1930 Mrs Helen E. Patterson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillborn Aug 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930 to Aug 25, 1930
that I last saw h..... alive on Stillborn, 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Placenta previa
Had been dead for 2 days 6th Mo
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) W W Beck, M. D.
8/25, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: R. W. Swatmuscauch, Pingree Idaho — Date of Burial: Aug 28, 1930

20. Undertaker: Acting Raymond E. Baker — Address: Pingree, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 8 1930

PLACE OF BIRTH

County of Bingham

City of Blackfoot

No. R.D. #1 St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183635

Registration District No. 121 State File No.

Prim. Registration District No. 2194 Local Registrar's No. 264

FULL NAME OF CHILD Stillborn Chapman

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? | and | Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Aug 18 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Joseph Franklin Chapman	FULL MAIDEN NAME Blanche Hale
Residence (Usual place of abode) Blackfoot	Residence (Usual place of abode) Blackfoot
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday 30 (Years)
Birthplace Idaho (City and State or County)	Birthplace Utah (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / **Stillborn** } **at** 10:00 P. M. **on the date above stated.**

(Signature) W W Beck

(Physician or ~~midwife~~)

Address Blackfoot Idaho

Filed Sept. 4 1930 Mrs Helen E Watrie

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

Local Registrar's No. _____

FULL NAME OF CHILD _____

(If mother selects the week "Selection" for name of child)

Sex _____ Twin or triplet (state which) _____ Number in order of birth _____ Legitimate or illegitimate _____ Date of birth _____

Was prophylaxis was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

(b) Born alive but now dead _____

MOTHER

FULL NAME _____

MAIDEN NAME _____

Residence (Usual place of abode) _____

Residence (Street and number or rural route) _____

Residence (City or town, or R.F.D. route) _____ Age at last birthday _____ (Years)

Color or race _____ Age at last birthday _____

Birthplace _____

(City and state or country)

Occupation _____ Nationality _____

(Country)

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*)

I hereby certify that I attended the birth of this child, who was born alive on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

If there was no attending physician or midwife, then the father, householder, or other person must report. A midwife is one that delivers for fees. Any person over eighteen of life after birth.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71015

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 27
Primary Registration District No. 2794
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 124

300

2. FULL NAME Stillborn Chapman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): Aug 18, 1930

7. AGE: Years | Months | Days: Stillborn | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Blackfoot Idaho

PARENTS

10. NAME OF FATHER: Joseph Franklin Chapman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Blanche Hale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan Utah

14. Informant: Joseph F. Chapman
(Address): Blackfoot Idaho R.R. #1

15. Filed: Aug 19, 1930 Mo Valentine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 10, 1930
that I last saw h alive Stillborn, 19
and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:
Premature birth
6th mo
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Placenta previa
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) W W Beck, M. D.
8/18, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: G.C. Cem. Blackfoot | Date of Burial: Aug 19 1930

20. Undertaker: Jos. F. Chapman | Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of [illegible]

City of Hailey

No. ..... St. .....

(If born in hospital or institution give name.)

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183656

Registration District No. 57 State File No. .....

Prim. Registration District No. 2022 Local Registrar's No. 41

FULL NAME OF CHILD Stillborn Jacobs

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	19 (Year)
Female				Yes	7	26	30

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	George Jacobs	FULL MAIDEN NAME	Evelyn Lelah Stitts
Residence (Usual place of abode)	Hailey, Idaho	Residence (Usual place of abode)	Hailey, Idaho
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	23	Age at last Birthday (Years)	19
Birthplace (City and State or Country)	Hailey, Idaho	Birthplace (City and State or Country)	Bellevue, Idaho
Occupation	Miner	Occupation	Woman work

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 5 a. m. M. on the date above stated.

(Signature) E. W. Pt

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Hailey, Idaho

Filed 8-30 1930 Ethel H. Wright

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 2

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71C

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 24

PLACE OF DEATH

County of Blaine

City of Hailey

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bailey Jacobs

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months: Still born | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: —

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hailey, Idaho

PARENTS

10. NAME OF FATHER: Jerry Jacobs

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hailey, Idaho

12. MAIDEN NAME OF MOTHER: Evelyn D. Stotts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bellevue, Idaho

14. Informant: Jerry Jacobs

(Address): Hailey, Idaho

15. Filed 8-30, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) — 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h..., alive on ....., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Still born 7/26-30 —
Strangulated twisted cord

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Hydro cephalus

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. W. Pat, M. D.

7/24, 1930 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey, Idaho | Date of Burial: 7/24 1930

20. Undertaker | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth or miscarriage.** State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Blaine

City of Hailey

No. ..... St.

795-214-007-319

(If born in hospital or institution give name.)

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 183660

Registration District No. 57 State File No. .....

Prim. Registration District No. 2028 Local Registrar's No. 37

FULL NAME OF CHILD Pierce

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female			Yes	9 – 14 – 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	James L Pierce	FULL MAIDEN NAME	Ida Carey
Residence (Usual place of abode)	Carey Idaho	Residence (Usual place of abode)	Carey Idaho
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	
Age at last Birthday (Years)	33	Age at last Birthday (Years)	34
Birthplace (City and State or Country)	New Mexico	Birthplace (City and State or Country)	Carey, Idaho
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 1 9 M. on the date above stated.

(Signature) E. W. Fox

Physician

(Physician or midwife)

Address Hailey Idaho

Filed 8-30 1930 H. H. Wright

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME Baby Pierce

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year):

7. AGE: Stillborn — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: X
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Hailey

PARENTS
10. NAME OF FATHER: James C. Pierce
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Mexico
12. MAIDEN NAME OF MOTHER: Ida Carey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: James C. Pierce
(Address) Carey Idaho

15. Filed 8-30, 1930 P. F. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/14, 1930, to 7/14, 1930
that I last saw h[illegible] alive on 7/14, 1930
and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows: Stillborn — Placenta Previa in mother, Separation of Placenta & loss of blood
Premature Fetus (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.
7/14, 1930 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carey Idaho — Date of Burial: July 15 1930

20. Undertaker: Harris & Amos — Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

183660 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 2 1930

County of Blaine

City of Hailey

No. 493-224-002-415 St.

Hailey Clinic

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 183667

Registration District No. 57 State File No.

Prim. Registration District No. 5022 Local Registrar's No. 53

FULL NAME OF CHILD (Stillborn) Marilyn Pilworth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female		Yes	8-24 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	William Fredrick Pilworth	FULL MAIDEN NAME	Sarah Davis
Residence (Usual place of abode)	Carey, Idaho	Residence (Usual place of abode)	Carey, Idaho
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	35	Age at last Birthday (Years)	34
Birthplace (City and State or Country)	Iowa	Birthplace (City and State or Country)	Paris Idaho
Occupation	Farmer	Occupation	House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 3.20 P. M. on the date above stated.

(Signature) F. W. Ist

Physician

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Hailey, Idaho

Filed 8-30 1930 Robert H. Wright

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 716

Local Registrar's No. 25

Registration District No. 57

Primary Registration District No. 2025

PLACE OF DEATH

County of Blaine

City of Carey

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Dilworth

Sole

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months | Days | If LESS than 1 day, Stillborn hrs. or min.

8. OCCUPATION OF DECEASED —

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hailey, Idaho

PARENTS

10. NAME OF FATHER William Fredrick Dilworth

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Sarah Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paris Idaho

14. Informant W. F. Dilworth

(Address) Carey, Idaho

15. Filed 8-30, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 - 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows: Stillborn. Hemorrhage Umbilical Cord. Placenta Previa

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

8/24, 1930 (Signed) [illegible] M. D. (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carey, Idaho | Date of Burial 8/25 1930

20. Undertaker X | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

IVED OCT 15 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho SEP 22 1930

183667

Mrs. W.F. Dilworth
Carey

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD ~~Mary~~ Marilyn Dilworth

PLACE OF BIRTH Hailey DATE OF BIRTH Aug. 24, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth One
2. Number born alive and now living None
3. Born alive but now dead "
4. Number of children stillborn One

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
William Fredrick Dilworth (Full name)	Sarah Davis Dilworth (Full maiden name)
Carey Idaho (Residence)	Carey Idaho. (Residence)
Age at last birthday 36	Age at last birthday 35
Provo Utah (Birthplace)	Paris, Idaho. (Birthplace)
Sheep-Man (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Cassia

City of Burley

No. 221 S. Overland St.

(If born in hospital or institution give name.)

RECEIVED AUG 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

183793

Registration District No. 117 State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stillbirth - Ardell Phillips

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
boy				Yes	July 22 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn 1

FATHER	MOTHER
FULL NAME Jack Silas Phillips	FULL MAIDEN NAME Bessie Ila Hoyley
Residence (Usual place of abode) 221 S. Overland	Residence (Usual place of abode) 221 S. Overland
If non-resident, give place and State	If non-resident, give place and State
Color or race white Age at last Birthday 30 (Years)	Color or race white Age at last Birthday 19 (Years)
Birthplace Keokuk, Iowa (City and State or County)	Birthplace Burley, Idaho (City and State or County)
Occupation Cook	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born Alive~~ / Stillborn} at 3 50/60 o'clock P. M. on the date above stated.

(Signature) Adam T. Magee, M.D.

(Physician or midwife)

Address Burley, Idaho

Filed 8-20-1930 F. H. Butler

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71655

PLACE OF DEATH

County of Cassia

City of Burley

CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ardell Phillips 304

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M | 4. COLOR OR RACE W | 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 22 1930

7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
Still Born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER Jack P. Phillips

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Bessie Ila Dayley

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Burley

14. Informant Jack Phillips
(Address) Burley Ida

15. Filed 7-20-, 1930 E. H. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 22, 1930, that I last saw h... alive on ....., 19..... and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Umbilical cord wound around neck (twice around) Strangulation from tightening of cord
..... (duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Roland Frazier, M. D.
....., 19..... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal: Burley Ida | Date of Burial: July 22 1930

20. Undertaker: D. E. Johnson | Address: Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED AUG 23 1930

PLACE OF BIRTH

County of Cassia

City of Burley

No. 320 N. Miller St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183792

Registration District No. 47 State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
boy				yes	July 16 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 3

FATHER	MOTHER
FULL NAME Edward H. Stewart	FULL MAIDEN NAME Neta Edna Frank
Residence (Usual place of abode) Jarbridge, Nevada	Residence (Usual place of abode)
If non-resident, give place and State	If non-resident, give place and State Jarbridge, Nevada
Color or race White Age at last Birthday 29 (Years)	Color or race White Age at last Birthday 26 (Years)
Birthplace Salina, Kansas (City and State or County)	Birthplace Ogden, Utah (City and State or County)
Occupation Miner	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 8:00 A. M. on the date above stated.

(Signature) Delmar Fraizer, M.D.

(Physician or midwife)

Address Burley, Idaho

Filed 8-20-1930 F. H. Curtis

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF PUBLIC WELFARE
DIVISION OF VITAL STATISTICS
REGISTRATION OF BIRTH

Registration District No. _____ State File No. _____

Prior Registration District No. _____ Local Registrar's No. _____

FIRST NAME OF CHILD _____

(If stillborn, substitute the word "stillborn" for name of child)

Sex of child _____ Twins? or triplets? _____ Number in order of birth _____ Single, twin, triplet, etc. _____ Date of birth _____ 19__

(To be answered only in case of live birth)

Were prophylactic eye drops (to prevent Ophthalmia Neonatorum) _____

Number of child of this mother including present birth _____

(a) Born alive and now living _____

Born alive but now dead _____

(b) Stillborn _____

FATHER		MOTHER	
FULL NAME		FULL MAIDEN NAME	
Residence (street and number or place)		Residence (street and number or place)	
Residence (city or town)		Residence (city or town)	
Residence (county)		Residence (county)	
Color or race _____ Age at last birthday _____ (years)		Color or race _____ Age at last birthday _____ (years)	
Birthplace (city or town and state or country)		Birthplace (city or town and state or country)	
Occupation		Occupation	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive on the date above stated.

Stillborn

(Signature) _____ M.D.

(Physician or midwife)

Address _____

Filed _____ 19__

Registrar

Where there was no attending physician or midwife, then the father, householder, etc., should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED AUG 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7169

PLACE OF DEATH
County of Cassia
City of Burley

CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. .....
(No. .....)
Local Registrar's No. .....

(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Baby Steward

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (Write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 16 1930

7. AGE Years: Still Born; Months: ; Days: ; If LESS than 1 day, ... hrs, or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Edward Steward
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Kansas
12. MAIDEN NAME OF MOTHER Neta Fronk
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah

14. Informant Mrs. A. C. Fronk
(Address) Burley Ida

15. Filed 8-20-, 1930 F. H. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16 1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 16, 1930, that I last saw he alive on ....., 19..... and that death occurred on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature - Not of viable age - Abortion 5 months gestation
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Nelson Frazier M. D.
....., 19..... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal: Burley Ida
Date of Burial: July 16 1930

20. Undertaker D. E. Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 8 1930

PLACE OF BIRTH

County of Franklin

City of Preston Idaho

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183808

Registration District No. 27 State File No. .....

Prim. Registration District No. 2119 Local Registrar's No. 186

FULL NAME OF CHILD stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female	(To be answered only in event of plural births)	4	yes	8 5 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead none Stillborn 2

FATHER		MOTHER	
FULL NAME	Carl Geo Neilson	FULL MAIDEN NAME	Vera Abray
Residence (Usual place of abode)	Preston Idaho	Residence (Usual place of abode)	Preston Idaho
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	29	Age at last Birthday (Years)	26
Birthplace (City and State or County)	Hyrum Utah	Birthplace (City and State or County)	Paradise Utah
Occupation	Farmer	Occupation	Hand Mop

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } **at** 11 30 A. **M. on the date above stated.**

(Signature) Thos B Walder

Physician

(Physician or midwife)

Address Preston Idaho

Filed 8/11/30 19 ..... J. A. Miller

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
(Name of Agency of Origin)

Registration District No. ..... Birth No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

(If mother, substitute the word "father" for name of child)

Sex of child	Twin or triplet?	Number in order of birth	Length	Date of birth	Hour
	(If twin, triplet, etc., entered only in event of birth)			(Month) (Day)	(Year)

Was prophylaxis was used to prevent Ophthalmia Neonatorum?

Mother alive but now dead ..... Mother alive but now dead

Mother's maiden surname ..... Mother's maiden surname

Residence (Usual place of abode) ..... Residence (Usual place of abode)

If non-resident, give place and date ..... If non-resident, give place and date

Color or race ..... Color or race at last Birthday (Year)

Birthplace (City and state or country) ..... Birthplace (City and state or country)

Occupation ..... Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at ..... on the date above stated.

(Signature) .....

(Type or print name)

Address .....

Where there was no attending physician or midwife, then the father, householder, or nearest relative in the room, shall report the birth.

In lieu of other evidence of life after birth, a stillborn child is one that neither breathes nor exhibits any other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED SEP 2 1930

PLACE OF BIRTH

County of Gooding

City of Wendell

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

183897

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD — Stillborn —

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	Number in order of birth	Legitimate?	Date of birth
male	one	and	yes	July 5 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Vernon C. Iverson	FULL MAIDEN NAME Thelma Johnson
Residence (Usual place of abode) Wendell Idaho	Residence (Usual place of abode) Wendell Idaho
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 30 (Years)	Color or race White Age at last Birthday 28 (Years)
Birthplace Utah (City and State or County)	Birthplace Mexico (City and State or County)
Occupation Farmer	Occupation Home Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 4 P. M. on the date above stated.

(Signature) Chas F. Zeller M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Jerome Idaho

Filed ..... 19..... .....

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Gooding

City of Wendell

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Iverson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wendell Idaho

PARENTS

10. NAME OF FATHER Vernon C Iverson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Thelma Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Vernon C Iverson
(Address) Wendell Idaho

15. Filed Sept 2, 1930 E L Simonton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 5, 1930
~~That I last saw h alive on~~ 1930
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Premature Separation Placenta

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. Zeller M. D.
7/10, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. **If the information cannot be secured, it should be plainly stated unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184021

PLACE OF BIRTH

County of Kootenai

City of Coeur d'Alene

No. ..... St. 912-116.028-152

(If born in hospital or institution give name.)

Registration District No. 30 State File No. .....

Prim. Registration District No. 10 Local Registrar's No. 157

FULL NAME OF CHILD Keith Rasmussen

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	8 16 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 7 (a) Born alive and now living 0

Born alive but now dead 6 Stillborn 1

FATHER		MOTHER	
FULL NAME	Harry Walter Rasmussen	FULL MAIDEN NAME	Eva Johanna Jensen
Residence (Usual place of abode)	Coeur d'Alene Ida	Residence (Usual place of abode)	Coeur d'Alene Ida
If non-resident, give place and state		If non-resident, give place and state	
Color or race	White	Color or race	White
Age at last Birthday (Years)	23	Age at last Birthday (Years)	21
Birthplace (City and State or County)	Kalispell Mont	Birthplace (City and State or County)	Elmira Wash
Occupation	Laborer	Occupation	Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 7 P. M. on the date above stated.

(Signature) E. H. Geed M.D.

(Physician or midwife)

Address Coeur d'Alene Ida

Filed 8/29 1930 N. J. Sturgeon Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. 184051

(If born in hospital or institution give name.)

Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillborn" for name of child)

Sex of child	Twin, Triplet or sextuplet	Number in order of birth	Legitimate?	Date of birth		
		(To be answered only in case of twins)		(Month)	(Day)	(Year)

What propylaxis was used to prevent ophthalmia Neonatorum? .....

Number of child of this mother, including present birth ..... (a) Boys still and now living .....

Boys alive but now dead ..... Stillborn .....

CHILD
NAME

MOTHER
MAIDEN
NAME

FULL
MAIDEN
NAME

Residence (Usual place of abode) .....

Residence (Usual place of abode) .....

If non-resident, give place and state .....

If non-resident, give place and state .....

Color or race ..... Age at last birthday ..... (Years)

Color or race ..... Age at last birthday ..... (Years)

Birthplace ..... (City and State or Country)

Birthplace ..... (City and State or Country)

Occupation .....

Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... on the date above stated.

(Signature)

(Physician or midwife)

Address .....

Filed ..... 19..... Registrar

When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71752

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No.) Local Registrar's No. 119
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Keith Rasmussen

(a) Residence. No. 817 3rd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930 - 8 - 16

7. AGE Years | Months | Days | If LESS than 1 day, 0 hrs. or 0 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene (State or country) Idaho

PARENTS
10. NAME OF FATHER Harry Rasmussen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kalispel. Mont.
12. MAIDEN NAME OF MOTHER Eva Jessen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dalton Gardens. Idaho

14. Informant Harry Rasmussen
(Address) Coeur d'Alene

15. Filed 8/29 1930. N. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-16- 1930, to 8-16- 1930
that I last saw h. — alive on Stillborn 19
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Stillborn
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. H. Reed, M. D.
8-18- 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Lawn. C'D'Alene — Date of Burial 8-18 1930
20. Undertaker Cassidy Funeral Home — Address C'D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

184021

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 11 1930

County of Kootenai

City of Coeur d'Alene

No. ..... St. 769 207 028 819

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 184023

Registration District No. 30 State File No.

Prim. Registration District No. 1050 Local Registrar's No. 159

FULL NAME OF CHILD Ida Evelyn Gordon

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child female | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth 6 (Month) 7 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME George Lyle Gordon	FULL MAIDEN NAME Mary Estella Harris
Residence (Usual place of abode) Coeur d'Alene	Residence (Usual place of abode) Coeur d'Alene
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 27 (Years)	Color or race White Age at last Birthday (Years)
Birthplace St Maries Ida (City and State or County)	Birthplace Darby Mont (City and State or County)
Occupation Logger	Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 10.50 A.M. on the date above stated.

(Signature) E H Teed M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Coeur d'Alene Ida

Filed 8/29 1930 N. J. Sturgeon

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

15402

Registration District No. ..... State File No. .....

(If born in hospital or institution) (Name of hospital or institution) (Street or R.F.D. number) (City or town) (County) (State)

Registrar's District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, superimpose the word "Stillborn" for name of child)

Sex of Child ..... Twin, Triplet or Other? ..... Number in order of birth ..... Legitimate? ..... Date of birth ..... (Month) (Day) (Year) Hour .....

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER

FULL NAME .....

Residence (Usual place of abode) .....

If non-resident, give place and date .....

Color or race ..... Age at last birthday ..... (Years)

Birthplace ..... (City and State or Country)

Occupation .....

MOTHER

FULL MAIDEN NAME .....

Residence (Usual place of abode) .....

If non-resident, give place and date .....

Color or race ..... Age at last birthday ..... (Years)

Birthplace ..... (City and State or Country)

Occupation .....

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19..... Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71073

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. Coeur d'Alene Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 75

2. FULL NAME Ida Evelyn Gordon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE Wh
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Ida

PARENTS

10. NAME OF FATHER George Gordon
11. BIRTHPLACE OF FATHER (city or town) St. Maries
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Stella Harris
13. BIRTHPLACE OF MOTHER (city or town) Montana
(State or Country)

14. Informant A. C. Worland
(Address) Coeur d'Alene Idaho

15. Filed 6/16, 1930 H. J. Sturges M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Stillborn
..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) C. H. Teed, M. D.
6-8, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery Coeur d'Alene — Date of Burial: 6/8 1930

20. Undertaker: Forest Funeral Home Coeur d'Alene — Address: Coeur d'Alene Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 10 1934

County of Shoshone

City of Wallace, Idaho

No. St. Joseph's St.

Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184169

Registration District No. 96 State File No.

Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male

Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births)

Legitimate? Yes

Date of birth: 8 (Month) 20 (Day) 1934 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1 Stillborn

FATHER		MOTHER	
FULL NAME	Chester Roberts	FULL MAIDEN NAME	Nora Weaver
Residence (Usual place of abode)	Cloverleaf	Residence (Usual place of abode)	Cloverleaf, Idaho
If non-resident, give place and State	Wash —	If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday	40 (Years)	Age at last Birthday	39 (Years)
Birthplace (City and State or County)	Nebraska	Birthplace (City and State or County)	Lord Cooke
Occupation	Farmer	Occupation	Housewife —

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 4:55 P. M. on the date above stated.

(Signature) E. G. Broadock

Physician —

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 9-2 1934 F. W. Lyle

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

PLACE OF BIRTH

County of .....

City of .....

No. ..... St.

Registration District No. ..... Name File No. .....

(If born in hospital or institution give name)

Idaho Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillborn" for name of child)

Sex of child	Twin, triplet or others?	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)	Is .....

(Use separate line for each child)

What prophylactic was used to prevent ophthalmia neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER

NAME .....

RESIDENCE

Residence (Usual place of abode) ..... Residence (Usual place of abode) .....

If non-resident, give place and state ..... If non-resident, give place and state .....

Color or race ..... Age at last birthday ..... (Years) Color or race ..... Age at last birthday ..... (Years)

Birthplace ..... (City and State or Country) Birthplace ..... (City and State or Country)

Occupation ..... Occupation .....

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive or stillborn at ..... on the date above stated.

(Signature)

(Physician or midwife)

Address .....

Filed ..... 19.....

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

*HERE DETACH WITH PERFORATION. IF—THERE IS A TRANSPORTATION RECORD

If—In case of more than one child, add another certificate for each child. Use separate sheet for each child and file with the other certificate. Be sure to give the place of birth.

RECEIVED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71800

PLACE OF DEATH

County of Nezperce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

204

2. FULL NAME George Roberts

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 20, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Stillborn			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Ida.

PARENTS

10. NAME OF FATHER C E Roberts

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Springfield Nebr

12. MAIDEN NAME OF MOTHER Nora Weaver

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant C E Roberts (Father)

(Address) Cloverland, Wash

15. Filed 9-1-30, 19 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 20, 1930 that I last saw h alive on never, 19 and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Still Born Premature Delivery

(duration) yrs. 5 mos. ' ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E G Broadrick, M. D.

Aug 29, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Wash	8/21/30 19

20. Undertaker H.R.Merchant Address Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Owyhee

City of Malad

No. ..... St. .....

(If born in hospital or institution give name.)

RECEIVED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184192

Registration District No. 26 State File No. .....

Prim. Registration District No. 20 6 9 Local Registrar's No. 95

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child male | Twin Triplet or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth Aug (Month) 7 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 4 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME William N. Gottrel	FULL MAIDEN NAME Mary Elizabeth Mulle
Residence (Usual place of abode) Downey, Ida.	Residence (Usual place of abode) Downey
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 22 (Years)	Color or race white Age at last Birthday 17 (Years)
Birthplace Downey, Ida. (City and State or Country)	Birthplace Rigby Ida (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 6 a.m. M. on the date above stated.

(Signature) U. P. Grant
Physician
(Physician or midwife)

Address Malad Ida.

Filed 8/31 1930 J. W. Kerns
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

N. B.—Every item of information should be carefully supplied. AGE should be stated. [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REGISTERED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2064

Local Registrar's No. 30

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born (No name) Cottrell 206

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 2. 1930

7. AGE: Years: Still Born; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Malad Idaho

PARENTS
10. NAME OF FATHER: Wm N Cottrell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Marsh Valley Idaho
12. MAIDEN NAME OF MOTHER: May Mulder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rigby Idaho

14. Informant: W. N. Cottrell.
(Address): Danny Idaho.

15. Filed 8/31, 1930 J. M. Evans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 2, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from born b. A.A., 19, to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:
Stillborn, lead over lap, ping twice around neck.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) V. P. Garst, M. D.
Aug 2, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida — Date of Burial: Aug. 2 1930

20. Undertaker: J. Guy Benson — Address: Malad Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED SEP 15 1930

PLACE OF BIRTH

County of Payette

City of New Plymouth

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184198

Registration District No. 5 State File No. .....

Prim. Registration District No. 2009 Local Registrar's No. 15

FULL NAME OF CHILD Infant Darnell (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Male				Yes	Aug 30 (Month) (Day) 1930 (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Glenn McClellan Darnell	FULL MAIDEN NAME	Bertha Wells
Residence (Usual place of abode)	New Plymouth, Ida	Residence (Usual place of abode)	With Husband
If non-resident, give place and State		If non-resident, give place and State	
Color or race	W	Color or race	W
Age at last Birthday (Years)	43	Age at last Birthday (Years)	40
Birthplace (City and State or County)	Nebr	Birthplace (City and State or County)	Kans
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } **at** 12 **M. on the date above stated.**

(Signature) Wm. J. Drysdale M.D.
(Physician or midwife)

Address New Plymouth Ida

Filed Sept 1 1930 Wm. J. Drysdale
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 1 0 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71

PLACE OF DEATH
County of Payette
City of New Plymouth

Registration District No. 5
Primary Registration District No. 2009 Local Registrar's No. 8
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Darnell

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) ✓

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Aug 30 - 1930

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stillborn Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Plymouth, Ida

PARENTS
10. NAME OF FATHER Glenn C. Darnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebr
12. MAIDEN NAME OF MOTHER Bertha Wells
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kans

14. Informant Wm J. Drysdale
(Address)

15. Filed Sept 1, 1930 Wm J. Drysdale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 30, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Contracted maternal pelvis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm J. Drysdale, M. D.
Aug 30, 1930 (Address) New Plymouth

19. Place of Burial, Cremation, or Removal: New Plymouth, Ida — Date of Burial: Aug 30 1930

20. Undertaker: Father of child — Address: New Plymouth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Saleman**, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At Home**, and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma**, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 184211

PLACE OF BIRTH
County Power
City of Ames Falls
No. St.
Belhaven
(If born in hospital or institution give name.)

Registration District No. 25 State File No.
Prim. Registration District No. 2072 Local Registrar's No. 60

FULL NAME OF CHILD o Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth Aug (Month) 12 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? o

Number of child of this mother, including present birth 6 (a) Born alive and now living 4
Born alive but now dead — Stillborn one

FATHER,
FULL NAME Jasper T. O'Hara
Residence (Usual place of abode) Pow Idaho
If non-resident, give place and State o
Color or race white Age at last Birthday 53 (Years)
Birthplace Oregon (City and State or County)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Hilda C. Peterson
Residence (Usual place of abode) Pow Idah
If non-resident, give place and State o
Color or race white Age at last Birthday 42 (Years)
Birthplace Oregon (City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at — M. on the date above stated.

(Signature) C. F. Schiller M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 9-8 1930 Genevieve Notts
Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 23

Primary Registration District No. 2072

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

2. FULL NAME ~~Gerald O'Harra~~ no name (Baby O'Harra) 2011

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 12th 1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ~~American Falls, Idaho~~

PARENTS

10. NAME OF FATHER: J.T. O'Harra

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Hilda C. Peterson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ore

14. Informant: J. T. O'Harra
(Address) Roy, Idaho

15. Filed Aug. 2, 1930 Gwenen Roth Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 12th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born child

two weeks before full term

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. F. Schultz, M. D.

Aug 12th, 1930 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rockland, Idaho | Date of Burial: 8/12/30 19

20. Undertaker: A. W. Davis | Address: American Falls Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Teton

City of Victor

No. ..... St.

(If born in hospital or institution give name.)

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184247

Registration District No. 77 State File No.

Prim. Registration District No. 2176 Local Registrar's No. 14

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child M | Twin Triplet or other? | and | Number in order of birth (To be answered only in event of plural births) | Legitimate? + | Date of birth 8/7 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Thos. N. Cherry	FULL MAIDEN NAME Della Hale
Residence (Usual place of abode) Victor, Ida. R.F.D.	Residence (Usual place of abode) Do.
If non-resident, give place and State —	If non-resident, give place and State —
Color or race W Age at last Birthday 32 (Years)	Color or race Do Age at last Birthday 32 (Years)
Birthplace Ida (City and State or County)	Birthplace Ida (City and State or County)
Occupation Rancher	Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 7.30 A. M. on the date above stated.

(Signature) L. R. Pedersen M.D.

(Physician ~~or midwife~~)

Address Driggs, Idaho

Filed 9-9-1930 Martha Marker

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[redacted]

DEPARTMENT OF [redacted]

BUREAU OF [redacted] STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

(If the Registration District No. ..... Local Registrar's No. .....

(If the birth took place in hospital or institution give name instead)

FULL NAME OF CHILD .....

(If still-born, substitute the word "Still-born" or name of child)

Sex of Child	Twin, Triplet or other	Number of child in order of birth	Legitimate?	Date of birth	19
		(Tick numerical order in case of multiples)		(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother including present birth ..... Born alive and now living .....

Born alive but now dead ..... Stillborn .....

	FATHER	MOTHER
NAME		
Residence (Usual place of abode)		
If a metropolitan area, ward and boro		
Date of birth	Age at last Birthday (Years)	Age at last Birthday (Years)
Birthplace (City and State or country)		
Occupation		

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19 ..... Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[redacted]

[redacted] OF BIRTH

County of .....

City of .....

No. ..... St. .....

(If the birth took place in hospital or institution give street number)

FULL NAME OF CHILD .....

(If still-born, substitute the word "Still-born" or name of child)

Sex of Child	Twin, Triplet or other	Number of child in order of birth	Legitimate?	Date of birth	19
		(Tick numerical order in case of multiples)		(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother including present birth ..... Born alive and now living .....

Born alive but now dead ..... Stillborn .....

	FATHER	MOTHER
NAME		
Residence (Usual place of abode)		
If a metropolitan area, ward and boro		
Date of birth	Age at last Birthday (Years)	Age at last Birthday (Years)
Birthplace (City and State or country)		
Occupation		

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19 ..... Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WARNING: PENALTY WITH $1,000 FINE OR 1 YEAR IMPRISONMENT INCURRED BY ANY PERSON WHO WILLFULLY MAKES ANY FALSE STATEMENT IN A CERTIFICATE OF BIRTH, DEATH OR FETAL DEATH. (SECTION 1743 PENAL LAW)

N. B.—In case of more than one child, use one blank for each child.

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Teton

City of Victor

Registration District No. 77

Primary Registration District No. 2176

Local Registrar's No. 5

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Otile Roberts

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 8/7/30

7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Teton Co., Victor, Ida

PARENTS

10. NAME OF FATHER Thos. W. Cherry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Della Hatch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida.

14. Informant Thos. W. Cherry
(Address) Victor, Ida.

15. Filed 9-2-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 / 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Compression of cord, on delivering after coming head. (breech case)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hydrocephalus
Spina Bifida

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. T. C. Tedrow, M. D.

8/8, 1930 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Victor, Ida — Date of Burial: 8-8-1930

20. Undertaker — Address —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

283 208-00-141

PLACE OF BIRTH

RECEIVED SEP 16 1930

County of Bonneville

City of Idaho Falls, Ida.

No. ..... St.

L.D.S. Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 73 State File No. 184341

Prim. Registration District No. 2-14-10 Local Registrar's No. 378

FULL NAME OF CHILD Stillborn Kilbrew

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Female				Yes	August 8 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead ..... Stillborn 1

FATHER		MOTHER	
FULL NAME	Roy Kilbrew	FULL MAIDEN NAME	Zena Adams
Residence (Usual place of abode)	Moreland, Idaho	Residence (Usual place of abode)	Moreland, Idaho
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	25	Age at last Birthday (Years)	20
Birthplace (City and State or County)	Thayer Kansas	Birthplace (City and State or County)	Idaho
Occupation	Farmer	Occupation	housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 4:32 a M. on the date above stated.

(Signature) H Ray Hatch M.D.

(Physician or midwife)

Address Idaho Falls Ida

Filed 8/13 1930 [illegible]

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

nod

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

REGISTERED SEP 16 1930

PLACE OF BIRTH

County of Bannock

City of Idaho Falls

No. ..... St.

463-104 OID-653

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184371

Registration District No. 73 State File No.

Prim. Registration District No. 110 Local Registrar's No. 348

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	Aug. 4 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

	FATHER	MOTHER
FULL NAME	Frank Earl Davis	FULL MAIDEN NAME Vida Fullmer
Residence (Usual place of abode)	Idaho Falls Ida	Idaho Falls Ida
If non-resident, give place and State		
Color or race	White	White
Age at last Birthday (Years)	33	30
Birthplace (City and State or County)	Dayton Ida	Preston Idaho
Occupation	Foreman Plumbing Co.	Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at ..... M. on the date above stated.

(Signature) [illegible] M.D.

(Physician or midwife)

Address Idaho Falls Ida.

Filed Aug 7 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 7122

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock

City of

Registration District No. 73

Primary Registration District No. 2 1 7 2

Local Registrar's No. 14 f

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Infant - Davis - Still Birth.

(a) Residence. No. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word.): —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 4 1930

7. AGE: Years | Months | Days: Still Birth | If LESS than 1 day, 0 hrs. or 0 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho

PARENTS

10. NAME OF FATHER Frank Earl Davis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dayton Ida

12. MAIDEN NAME OF MOTHER Velate Fellows

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Preston Ida

14. Informant Mrs Frank Davis
(Address) Idaho Falls Ida.

15. Filed Aug 8 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...

that I last saw him alive on — 19...

and that death occurred, on the date stated above, at ...m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Still birth - Premature birth - Intra uterine gestation 8 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

Aug 8 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: Aug 4 1930

20. Undertaker | Address

[signature]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PHYSICIAN

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Pocatello

No. 113-109 003-219 St.

CERTIFICATE OF BIRTH

Registration District No. 28 File No. 184514

Hospital

Primary Registration District No. 2161 Registered No. 9971

FULL NAME OF CHILD Still Born.

(Certificate of no value without full name of child.)

Sex of Child Male | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth 8-9-1930 (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	Cecil Jacobson	FULL MAIDEN NAME	Essie May Bonhart
RESIDENCE	Pocatello	RESIDENCE	Do-
COLOR	White	COLOR	White
AGE AT LAST BIRTHDAY (Years)	22-	AGE AT LAST BIRTHDAY (Years)	22-
BIRTHPLACE	Idaho	BIRTHPLACE	La-
OCCUPATION	Service station Prop.	OCCUPATION	Hsw.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~born alive or~~ stillborn) at 2 P- M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. Swiller

(Physician ~~or midwife~~)

Address Pocatello Idaho

Filed 10/1/1930 J. H. Young

Registrar.

Give names added from a supplemental report.

, 192

Registrar.

nod

238 112010 43 RECEIVED OCT 16 1930

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. ..... St.

Spencer Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184643

Registration District No. 13 State File No. .....

Prim. Registration District No. 210 Local Registrar's No. 392

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
Male	1		6	yes	Sept	17	1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 2

FATHER		MOTHER	
FULL NAME	Antone James Schwarzenberger	FULL MAIDEN NAME	Effa May McCowin
Residence (Usual place of abode)	Idaho Falls	Residence (Usual place of abode)	Idaho Falls
If non-resident, give place and State	Route #2	If non-resident, give place and State	RFD #2
Color or race	White	Color or race	White
Age at last Birthday (Years)	36	Age at last Birthday (Years)	36
Birthplace (City and State or County)	Meffins Wisconsin	Birthplace (City and State or County)	Weber Canyon Utah
Occupation	rancher	Occupation	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 3 10 P. M. on the date above stated.

(Signature) M L Lipsner M D

(Physician or midwife)

Address Idaho Falls Ida

Filed Sept 18 1930 [illegible]

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....
Place of birth or institution ..... Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child | Twin, Triplet or other | Number in order of birth | Legitimate? | Date of birth (Day) (Month) (Year)

(Use separate line for each of twins, etc.)

What prophylactic was used to prevent ophthalmia Neonatorum?

Number of child of this mother including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER

NAME ..... FULL NAME OF MOTHER ..... MAIDEN NAME .....

Residence (Usual place of abode) ..... Residence (usual place of abode) .....

Residence (Usual place of abode) ..... Residence (usual place of abode) .....

Color or race ..... Age at last birthday ..... (Years) Color or race ..... Age at last birthday ..... (Years)

Birthplace ..... Birthplace .....

(City and State or Country) (City and State or Country)

Occupation ..... Occupation .....

(Birth certificate of attending physician or midwife)

I hereby certify that I attended the birth of this child, who was born alive at ..... on the date above stated.

Signature .....

(Physician or midwife)

Address .....

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72000

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Idaho

Registration District No. 73
Primary Registration District No. 2140
(No. .....)

Local Registrar's No. 142

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 17-1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)

PARENTS

10. NAME OF FATHER Ultone James Schwarzenberger

11. BIRTHPLACE OF FATHER (city or town) Mauflins
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Erra Mae McCowin

13. BIRTHPLACE OF MOTHER (city or town) Weber Canyon
(State or County) Utah

14. Informant Antone J. Schwarzenberger
(Address) .....

15. Filed Sept. 17, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 17, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19....., to ..... 19.....
that I last saw him ..... alive on ..... 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn, premature
resection [illegible] Funis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
..... 19..... (Address) Idaho Falls Idaho

19. Place of Burial, Cremation, or Removal: Dacks Funeral Home
Date of Burial: Sept 18 1930

20. Undertaker: None
Address .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

184643 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED OCT 16 193

PLACE OF BIRTH
County of Bonneville
City of Idaho Falls
No. LDS Hospital
366-710-010-0243
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

184655

Registration District No. 23 State File No.
Prim. Registration District No. Local Registrar's No. 404

FULL NAME OF CHILD Still born Cook
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	Sept 10 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 13 (a) Born alive and now living 12
Born alive but now dead 12 Stillborn 1

FATHER	MOTHER
FULL NAME Jas Ed. Cook	FULL MAIDEN NAME Christina Mae Buckmiller
Residence (Usual place of abode) Idaho Falls Rt #5	Residence (Usual place of abode) Rt #5
If non-resident, give place and State	If non-resident, give place and State
Color or race white Age at last Birthday 49 (Years)	Color or race white Age at last Birthday 45 (Years)
Birthplace Sevier Co Utah (City and State or County)	Birthplace Rexburg (City and State or County)
Occupation farmer	Occupation None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 7 03 9 M. on the date above stated.

(Signature) [illegible]
[illegible] M.D.
(Physician or midwife)
Address Idaho Falls

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed Oct 13 1930 [illegible]
Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

184655 1

REGISTERED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72013

PLACE OF DEATH

County of Bonneville
City of Idaho Falls Ida

Registration District No.
Primary Registration District No.
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 179

2. FULL NAME Stillborn Cook

(a) Residence. No. Idaho Falls St. Rt. #5 200
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): newborn

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 10 1930

7 AGE: Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho Falls, Ida

PARENTS
10 NAME OF FATHER Jo. E. Cook
11 BIRTHPLACE OF FATHER (city or town) (State or country) Lincoln Co Utah
12 MAIDEN NAME OF MOTHER Christina M. Buchmiller
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rexburg Idaho

14 Informant J. C. Sandberg (Son-in-law)
(Address) Idaho Falls.

15 Filed Oct 14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. (Month) 10 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 10, 1930, that I last saw him alive on Sept 10, 1930, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:
Puerperal Hemorrhage
Premature separation
7 (duration) Placenta yrs. mos. ds.
CONTRIBUTORY (Secondary) death 2 days before birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination of Placenta
(Signed) [signature], M. D.
9/10, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Grant. Ida, 11 | Date of Burial: Sept. 1930

20. Undertaker: Jack A. Wood. | Address: Idaho Falls

A stillbirth must be registered both as a birth and a death. **The date of** death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma,** Carcoma, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis,** tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local **record.**

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars **should** be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED OCT 16 1930

County of Bonneville

City of Idaho Falls

No. 518-220-010-363 St.

L.D.S. Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. ..... State File No. 184668

Prim. Registration District No. ..... Local Registrar's No. 432

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
F			yes	Sept. 20 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER	MOTHER
FULL NAME: Ray Nahra	FULL MAIDEN NAME: Sue Mae Toliver
Residence (Usual place of abode): Idaho Falls, Idaho	Residence (Usual place of abode): Idaho Falls, Idaho
If non-resident, give place and State:	If non-resident, give place and State:
Color or race: W. Age at last Birthday: 43 (Years)	Color or race: W. Age at last Birthday: 19 (Years)
Birthplace: Syria (City and State or County)	Birthplace: Farber Missouri (City and State or County)
Occupation: Prop. Rexall store	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 10 15 P. M. on the date above stated.

(Signature) H. L. Wilson M.D.

(Physician ~~or midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho Falls Idaho

Filed Sept 23 1930 [illegible]

Registrar

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Local Registrar's No. .....

(If born in hospital, institution, give name.)

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillbirth" for name of child.)

Sex of Child	Twins or triplets?	Number in order of birth (To be answered only in case of twins)	Legitimate?	Date of birth (Month)	(Day)	19 (Year)

Was prophylactic *was* used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth ..... (a) Born alive now living .....

Born alive but now dead ..... Stillborn .....

FATHER		MOTHER
FULL NATIVE NAME	FULL MAIDEN NAME	

Residence (Number) .....

If non-resident, give place and state .....

Color or race ..... Age at last Birthday (Years) ..... Color or race ..... Age at last Birthday (Years) .....

Birthplace (City and state or country) ..... Birthplace (City and State or Country) .....

Occupation ..... Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... on the date above stated.

(Signature) .....

(Physician or Midwife)

Address .....

Filed ..... 19 .....

"Where there was no attending physician or midwife, then the father, house-holder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NOTICE: IT IS A VIOLATION OF LAW TO MAKE OR ALTER THIS CERTIFICATE.

Form 1 — 10 copies (red) 5 copies (blue) 10 copies (green) 10 copies (white) 10 copies (yellow) 10 copies (pink) 10 copies (orange) 10 copies (gray) 10 copies (brown) 10 copies (purple) 10 copies (black)

OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71999

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2 14-0
(No. St. Al's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 176

206

2. FULL NAME Mary Louise Nahra
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred, Life mos. Stillborn ds. If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Sept 20-1930
7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, hrs. or Stillborn
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida.

PARENTS
10. NAME OF FATHER: Ray Nahra
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Syria
12. MAIDEN NAME OF MOTHER: Lee Mae Tolliver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Ray Nahra
(Address): Idaho Falls Ida.
15. Filed Oct 2, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 20 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept. 20 1930
that I last saw her alive on ..... 19..
and that death occurred, on the date stated above, at 10.30 P.m.
The CAUSE OF DEATH* was as follows:
Stillborn – Premature
Mother threatened with Eclampsia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. L. Wilson M. D.
9/22, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial 9/21 1930
20. Undertaker: V. F. McHan | Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

184668

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of ~~[illegible]~~ RECEIVED SEP 24 1930

City of Challis

No. ..... St. 292 023 019 789

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 108 State File No. 184774

Prim. Registration District No. 2186 Local Registrar's No. 204

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
			Yes	July 23 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Charles Elmer Bishop	FULL MAIDEN NAME Laura Thelma Philips
Residence (Usual place of abode) Challis, Idaho	Residence (Usual place of abode) Challis, Ida.
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 43 (Years)	Color or race White Age at last Birthday 26 (Years)
Birthplace New London Iowa (City and State or County)	Birthplace Idaho Falls (City and State or County)
Occupation Rancher	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born Alive~~ Stillborn} at 1 a M. on the date above stated.

(Signature) C. L. Whitley M.D.

(Physician or midwife)

Address Challis, Idaho

Filed Aug 23 1930 Elma McKenney Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED SEP 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72049

PLACE OF DEATH

County of Custer
City of Challis

CERTIFICATE OF DEATH

Registration District No. 108
Primary Registration District No. 3186 Local Registrar's No. 107
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2010

2. **FULL NAME** Stillbirth

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23 1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work 4½ mo. gestation
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Challis, Idaho

PARENTS

10. NAME OF FATHER Charles Elmer Bishop Jr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New London Iowa
12. MAIDEN NAME OF MOTHER Laura Thelma Philips
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lewiston Idaho

14. Informant Laura Thelma Bishop
(Address)

15. Filed Aug 23, 1930 Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 23, 1930
that I last saw h— alive on ——, 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cause not known.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. L. Kirby M. D.
, 19 (Address) Challis Idaho

19. Place of Burial, Cremation, or Removal: Challis Idaho — Date of Burial: July 23 1930

20. Undertaker: Relatives — Address: Challis Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

184774

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

165-206 027 557

RECEIVED OCT 10 1930

PLACE OF BIRTH

County of Jerome

City of Jerome

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184873

Registration District No. 18 State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Chana Gomez

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? 2 and Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth Sept 6 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 20% Argyrol

Number of child of this mother, including present birth 11 (a) Born alive and now living 8

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Dauaciano Gomez	FULL MAIDEN NAME Augustina Negrete
Residence (Usual place of abode) Jerome Idaho	Residence (Usual place of abode) Jerome Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race Brown Age at last Birthday 42 (Years)	Color or race Brown Age at last Birthday 40 (Years)
Birthplace Mexico (City and State or County)	Birthplace Mexico (City and State or County)
Occupation Labor	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 1:30 P. M. on the date above stated.

(Signature) Chas F. Zeller M.D.

(Physician or midwife)

Address Jerome Idaho

Filed 9/7 1930 Chas F. Zeller Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 7 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho OCT 27 1930

184873

Mrs. D. Gomez
Jerome

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Chana Gomez

PLACE OF BIRTH Jerome DATE OF BIRTH Sept. 6, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 10
2. Number born alive and now living 7
3. Born alive but now dead 3
4. Number of children stillborn none

(Please write plainly)

Information with reference to FATHER

Donaciano Gomez
(Full name)

P.O. Box 434
(Residence)

Age at last birthday 47

Cañadas Jalisco Mexico
(Birthplace)

Laborer
(Occupation)

Information with reference to MOTHER

Agustina Negrete
(Full maiden name)

P.O. Box 434
(Residence)

Age at last birthday 38

Leon Gto. Mexico
(Birthplace)

none

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72074

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Gomez

(a) Residence. No. 0 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Mexican
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 6/30

7. AGE Years | Months | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Donaciano Gomez
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Augustina Negrete
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Donaciano Gomez
(Address) Jerome, Idaho

15. Filed 9/6, 1930 C. F. Zeller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1930, to Sept. 6, 1930
that I last saw him alive on Sept. 6, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
asphyxia due to breech
presentation with lodging
of after coming head
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. F. Zeller M. D.
9/6, 1930 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome, Idaho
Date of Burial: 9/6 1930

20. Undertaker
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Latah SEP 29 1930

City of Deary

No. ..... St.

155-215-029-494
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184917

Registration District No. 65 State File No.

Prim. Registration District No. 2145 Local Registrar's No.

FULL NAME OF CHILD Joan Avery (Baby Avery) (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? (To be answered only in event of plural births) } and { Number in order of birth | Legitimate? yes | Date of birth Aug. 15 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead x Stillborn 1

FATHER	MOTHER
FULL NAME Charles Avery	FULL MAIDEN NAME Bernadine Drury
Residence (Usual place of abode) Deary	Residence (Usual place of abode) Deary
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 29 (Years)	Color or race white Age at last Birthday 22 (Years)
Birthplace Michigan (City and State or Country)	Birthplace Idaho (City and State or Country)
Occupation Blacksmith	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 10:30 P. M. on the date above stated.

(Signature) Dr. J. C. Gibson
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Potlatch

Filed Aug 20 1930 Geo. Thompson
Registrar.

110D

RECEIVED NOV 19 1930

FORM V. S. NO. 27B. 5M-12-1

STATE OF IDAHO

BOARD OF HEALTH--BUREAU OF VITAL STATISTICS

SUPPLEMENTAL REPORT OF BIRTH

Place of Birth
City: Deary
Street and House No.:
County: Latah

Registered No. 65

Registration Dist. No. 2145

Sex of Child: Female

Date of Birth: Aug. 15 1930 (MONTH DAY YEAR)

Father: Charles Avery (FULL NAME)

Mother: Bernadine O. Drury (FULL MAIDEN NAME)

I Hereby Certify that the child described herein has been named:

Joan (GIVEN NAME IN FULL) Avery (SURNAME)

as reported by Mrs Charles Avery (FATHER OR MOTHER)

Dr. G. W. Thompson (LOCAL REGISTRAR)

396-218 029-795

RECEIVED OCT 14 1930

PLACE OF BIRTH

County of Latah

City of Moscow

No. 720 So Main St.

The Gritman

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 184941

Registration District No. 61 State File No.

Prim. Registration District No. 101 Local Registrar's No. 101

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female		Yes	Sept 18 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 1

FATHER		MOTHER	
FULL NAME	Alton Douglas Crowe	FULL MAIDEN NAME	Della Green
Residence (Usual place of abode)	Grangeville Ida.	Residence (Usual place of abode)	Grangeville Idaho
If nonresident, give place and State		If nonresident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	30	Age at last Birthday (Years)	27
Birthplace (City and State or Country)	Grangeville Idaho.	Birthplace (City and State or Country)	Moscow Idaho
Occupation	County Treas, Idaho County	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / Stillborn at 9:15 a. M. on the date above stated.

(Signature) Chas. L. Gritman

(Physician or ~~midwife~~)

Address Moscow Idaho

Filed 10/9 1930 [illegible] Reg

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72104

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No.) 300
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

2. FULL NAME (Still Born) Baby Crowe

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moscow Ida.

PARENTS

10. NAME OF FATHER Alton Crowe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grangeville Idaho

12. MAIDEN NAME OF MOTHER Della Green

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Moscow Idaho

14. Informant Alton Crowe
(Address) Grangeville Idaho

15. Filed, 19. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 18 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930, to Sept 18, 1930
that I last saw er XXX alive on Stillborn, 19
and that death occurred, on the date stated above, at 9:15 A m.
The CAUSE OF DEATH* was as follows:

Aborton 3rd month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? -- Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Fitzwater, M. D.
Sept 20, 1930 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow — Date of Burial: 9/21/30

20. Undertaker: R. M. Grim — Address: Moscow, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

184941 D

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED OCT 6 1930

County of Minidoka

City of Paul Ida

No. RY. 1 St.

296 107-034 349

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 184999

Registration District No. 19 State File No.

Prim. Registration District No. 2013 Local Registrar's No. 150

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male				yes	Aug 7 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 10 (a) Born alive and now living 7

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME John Broadhead	FULL MAIDEN NAME Etta Cuntas
Residence (Usual place of abode) Paul	Residence (Usual place of abode) Paul
If non-resident, give place and State Ida	If non-resident, give place and State Ida
Color or race W Age at last Birthday 61 (Years)	Color or race W Age at last Birthday 41 (Years)
Birthplace Sawyer Utah (City and State or County)	Birthplace Aurora Utah (City and State or County)
Occupation Farmer	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 5.45 p. M. on the date above stated.

(Signature) Leland Tracy, M.D.

(Physician or midwife)

Address Rupert, Idaho

Filed 9-12 1930 E. N. Ehmke

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[redacted]

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Minidoka
City of Paul

CERTIFICATE OF DEATH
Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Broadhead

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 7 1930

7. AGE: Years | Months | Days: Still Born
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Paul
(State or country) Idaho

PARENTS
10. NAME OF FATHER Jabez Broadhead
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Etta Curtis
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Utah

14. Informant J. Broadhead
(Address) Paul Ida

15. Filed Aug. 11, 1930 Ed E. Elmore
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 7 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 7, 1930
that I last saw him alive Still born Aug 7, 1930
and that death occurred on the date stated above at 8 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hydrocephalus
Pre-natal
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Roland Traum, M. D.
, 19 (Address) Rupert, Idaho

19. Place of Burial, Cremation, or Removal: Heyburn Ida
Date of Burial: Aug. 8 1930
20. Undertaker: R. C. Johnson
Address: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

184996

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

413-204035-132

PLACE OF BIRTH RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce

City of Lewiston

No. ..... St. Registration District No. 96 File No. 185017

Hospital ..... Primary Registration District No. 1009 Registered No. .....

FULL NAME OF CHILD Cora Katherine Mathews
(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes.	9-4-1930

What bactericidal solution was used in eyes? 2% Argyrol

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	Joseph Eugene Mathews	FULL MAIDEN NAME	Nellie Atkinson
RESIDENCE	Austin Wash.	RESIDENCE	Austin Wash.
COLOR	White	COLOR	White
AGE AT LAST BIRTHDAY (Years)	29	AGE AT LAST BIRTHDAY (Years)	20
BIRTHPLACE	Oklahoma.	BIRTHPLACE	Sask. Canada.
OCCUPATION	Laborer.	OCCUPATION	House wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn (Born alive or stillborn) **at** 2:45 P. M. **on the date above stated.**

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. Ronas M.D.
Lewiston, Ida.
(Physician or midwife)

Address Lewiston, Ida

Give names added from a supplemental report.

....., 192....

.....
Registrar.

Filed 10-7 1930 J. M. Lyle
Registrar.

N. B.—In case of more than ... and the number of ...

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72138

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 46
Primary Registration District No. 1809
(No. 404)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Howard Rouse
Local Registrar's No.

2. FULL NAME Cora Catherine Mathews

(a) Residence. No. Anatone Ave. St. Anatone Ave.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 4. 1930

7. AGE: Years | Months: Stillbirth | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho.

PARENTS
10. NAME OF FATHER: J. E. Mathews
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Okla.
12. MAIDEN NAME OF MOTHER: Nell Atkinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: ~~J. E. Ashare~~ J. E. Mathews
(Address) Asotin Wyn.

15. Filed Sept. 5, 1930 J. M. Tyler Registrar By MB

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4. 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-4-30, 19..., to 9-4-30, 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Stillbirth
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Negro.
(Signed) H. Rouse M. D.
9-3-30, 19... (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: 9/4 1930

20. Undertaker: Brown-Hauge Co | Address: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

185017

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH: DCT 7 1930

County of Ada

City of Meridian

No. 693 130-03 693 St.

Community Hospital (If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 18505 F

Registration District No. 26 State

Prim. Registration District No. 2069 Local Registrar's No. 113

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male				yes	Sept 30 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 5 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	William J. Williams	FULL MAIDEN NAME	Lenada E. Williams
Residence (Usual place of abode)	Meridian	Residence (Usual place of abode)	Meridian
If nonresident, give place and State		If nonresident, give place and State	
Color or race	white	Color or race	white
Age at last Birthday (Years)	46	Age at last Birthday (Years)	34
Birthplace (City and State or Country)	Provo Utah	Birthplace (City and State or Country)	Meridian Idaho
Occupation	Laborer	Occupation	House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 8:15 P. M. on the date above stated.

(Signature) [illegible]
Physician
(Physician or midwife)

Address Meridian Idaho

Filed 9/30 1930 J. M. Kerns
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ND

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE ~~RECEIVED~~ OCT 8 1930

County of Teton

City of Victor

No. ..... St.

231 713 041 363

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185146

Registration District No. 77 State File No. .....

Prim. Registration District No. 2176 Local Registrar's No. 21

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	9 – 13 – 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME W. F. Blanchard	FULL MAIDEN NAME Gladys Bartrell
Residence (Usual place of abode) Victor	Residence (Usual place of abode) —
If non-resident, give place and State	If non-resident, give place and State .....
Color or race W Age at last Birthday 35 (Years)	Color or race W Age at last Birthday 28 (Years)
Birthplace Victor Idaho (City and State or County)	Birthplace Payson Utah (City and State or County)
Occupation Farmer	Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12 P. M. on the date above stated.

(Signature) G. T. Parkinson

Phys.

(Physician or ~~midwife~~)

Address Driggs Idaho

Filed 10 – 4 – 1930 Martha Marker

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

FOR USE IN SECURING SOCIAL SECURITY BENEFITS

Registration District No. _____ Birth File No. _____

Place of birth: City or town _____ County _____

Full name of child _____

(If stillborn, substitute the word "stillborn" for name of child)

Sex _____ Twin, triplet, or quadruplet? _____ Number of child in order of birth _____ Legitimate? _____ Date of birth _____

Was prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

(b) Born alive but now dead _____ Stillborn _____

FATHER

FULL NAME _____

MAIDEN NAME _____

Residence (Street and number or place) _____

Residence (City or town) _____

Residence (County) _____

Residence (State or country) _____

Color or race _____ Age at last birthday _____ (years)

Birthplace (City or town, state or country) _____

Occupation _____ Industry _____

MOTHER

FULL NAME _____

MAIDEN NAME _____

Residence (Street and number or place) _____

Residence (City or town) _____

Residence (County) _____

Residence (State or country) _____

Color or race _____ Age at last birthday _____ (years)

Birthplace (City or town, state or country) _____

Occupation _____ Industry _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ (hour) on the date above stated.

(Signature) _____

Address _____

Where there was no attending physician or midwife, then the father, householder, or nurse should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72172

PLACE OF DEATH
County of Teton
City of Victor

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

306

2. FULL NAME Stillborn

(a) Residence. No. Victor Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6. DATE OF BIRTH (month, day and year): 9-13-1930

7. AGE: Years ~~1930~~ Months ~~13~~ Days — If LESS than 1 day, ✓ hrs. or ✓ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Victor Ida.

PARENTS
10. NAME OF FATHER: Wallace Fife Blanchard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Victor Ida.
12. MAIDEN NAME OF MOTHER: Gladys Cottrell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake Utah

14. Informant: Wallace F. Blanchard
(Address): Victor Ida.

15. Filed 10-4-, 1930 Martha Morker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept 13, 1930 that I last saw h. alive on ✓, 19 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Malformation
monstrosity
(duration) yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary)
(duration) yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. T. Parkinson, M. D.
9-14-, 1930 (Address) Dubois Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Victor, Ida — Date of Burial: 9-14-1930
20. Undertaker — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

168-211-041-396

PLACE OF BIRTH OCT 8 1930

County of Teton

City of Clementsville

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

185151

Registration District No. 77 State File No. .....

Prim. Registration District No. 2176 Local Registrar's No. 96

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Female				Yes	9 — 11 — 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth — (a) Born alive and now living —

Born alive but now dead — Stillborn 1

FATHER	MOTHER
FULL NAME Earl Johnson	FULL MAIDEN NAME Thelma Lovel
Residence (Usual place of abode) Clementsville	Residence (Usual place of abode) Clementsville
If non-resident, give place and State	If non-resident, give place and State
Color or race W Age at last Birthday 28 (Years)	Color or race W Age at last Birthday 20 (Years)
Birthplace Mt Pleasant, Utah (City and State or County)	Birthplace Kansas (City and State or County)
Occupation Farmer	Occupation H W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 4:30 P. M. on the date above stated.

(Signature) G G Parkinson
Phy
(Physician ~~or midwife~~)

Address Driggs, Idaho

Filed 10 — 4 — 1930 Martha Marker

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72173

County of Teton
City of Clementsville
Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

304

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) 9-11-1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	—

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Clementsville
(State or country) Idaho

PARENTS

10. NAME OF FATHER Earl Johnson
11. BIRTHPLACE OF FATHER (city or town) Mt Pleasant
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Thelma Liegel
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Kansas

14. Informant Earl Johnson
(Address) Clementsville Idaho

15. Filed 10-4-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-11, 1930, to 9-11, 1930
that I last saw h✓ alive on ✓, 19..
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows: Stillborn (Premature at 5 mo) Cause unknown
..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. T. Parkinson, M. D.
9-12-, 1930 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clementsville Id	9-12- 1930
20. Undertaker	Address
—	—

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED NOV 6 1930

PLACE OF BIRTH

County of ada

City of Boise

No. St. St. alphonsus

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 185275

Registration District No. 3 State File No.

Prim. Registration District No. 1004 Local Registrar's No. 520

FULL NAME OF CHILD ~~Stillbo~~ Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes.	Oct. 27 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 1

FATHER		MOTHER	
FULL NAME	Voyle Elmo Breshers	FULL MAIDEN NAME	Lilia Ada Hawes
Residence (Usual place of abode)		Residence (Usual place of abode)	
If non-resident, give place and State	Quartzburg Ida	If non-resident, give place and State	Same
Color or race	W	Color or race	W
Age at last Birthday (Years)	23	Age at last Birthday (Years)	21
Birthplace (City and State or County)	Boise Ida.	Birthplace (City and State or County)	Caldwell Ida.
Occupation	Miner	Occupation	None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 8:30 P.M. on the date above stated.

(Signature) Alfred Budge Jr. M.D.

M.D.

(Physician or ~~midwife~~)

Address Boise Ida

Filed 10-29 1930 W. H. Rhodes

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

.....

.....

(Physician or midwife)

Address .....

Filed 19

... stillborn
... neither breathes nor
... other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

Budge

NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72232

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 278
264

2. FULL NAME Baby Breshears

(a) Residence. No. St. Quartzburg, Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) October 27-1930

7. AGE: Years Hours; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Ida

PARENTS

10. NAME OF FATHER V. E. Breshears
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Lilla Hause
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant V. E. Breshears
(Address) Quartzburg Ida.

15. Filed 10 28 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 27
Unknown (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1930, to Oct 27 1930
that I last saw him ~~alive~~ on dead Oct 27 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ruptured uterus (Probably one week prior to operation)

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) Alfred Brady Jr., M. D.
...., 19.. (Address) ....

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Oct. 28 1930

20. Undertaker: Schreiber & McCann — Address: Boise, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

203-235

NOV 14 1930

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. St. Anthony St.

Hosp.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 28 State File No. 185343

Prim. Registration District No. 216 Local Registrar's No. 10 044

FULL NAME OF CHILD Stillborn Logan

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	10/9/30/ 19

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead Stillborn 1

FATHER	MOTHER
FULL NAME Ervin F. Logan	FULL MAIDEN NAME Lillie Stewart
Residence (Usual place of abode) 58 Wilwood Ave.	Residence (Usual place of abode) 58 Wilwood Ave
If non-resident, give place and State	If non-resident, give place and State
Color or race W Age at last Birthday 38 (Years)	Color or race W Age at last Birthday 34 (Years)
Birthplace Sedalia Mo. (City and State or County)	Birthplace Cedar City Utah (City and State or County)
Occupation Train Dispatcher	Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born Alive~~ Stillborn at 6:25 P. M. on the date above stated.

(Signature) [illegible]

(Physician ~~or midwife~~)

Address Pocatello, Ida.

Filed 11/1 1930 [illegible]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

185343 +

Received NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72259.

CERTIFICATE OF DEATH

- PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 29
Primary Registration District No. 2161 Local Registrar's No. 5921
(No. St. Anthony's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beverly Logan

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 9, 1930

7. AGE	Years	Months	Days	LESS than 1 day, hrs. or min.
	0	0	0	Still Born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Ervine F. Logan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Lillie Stewart
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Cedar City, Utah.

14. Informant Ervine F. Logan
(Address) 58 Willowood Ave. Pocatello, Ida.

15. Filed 10/11/30. 19 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 9, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Still Born Oct 9 1930 to
that I last saw h alive on 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Footbaby Birth Fusion head in transverse position in bony Pelvis. Forceps delivery
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) O. Tell, M. D.
10/10/30. 19 (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal Mountain View Cemetery Pocatello, Idaho. — Date of Burial 10/11/30. 19

20. Undertaker Arthur W. Hall — Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bear Lake

City of Paris

No. ..... St.

356-115-004-214

(If born in hospital or institution give name.)

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

185374

Registration District No. 53 State File No. .....

Prim. Registration District No. ..... Local Registrar's No. 535

FULL NAME OF CHILD .....
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate: Yes | Date of birth: Oct (Month) 15 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth: 4 (a) Born alive and now living: 3

Born alive but now dead: — Stillborn: 1

FATHER	MOTHER
FULL NAME: F. Ralph Lewis	FULL MAIDEN NAME: Martha Kaufmann
Residence (Usual place of abode): Paris	Residence (Usual place of abode): Paris
If nonresident, give place and State:	If nonresident, give place and State:
Color or race: White Age at last Birthday: 36 (Years)	Color or race: White Age at last Birthday: 33 (Years)
Birthplace (City and State or Country): Idaho	Birthplace (City and State or Country): Switzerland
Occupation: Merchant	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

Mother has spinal deformity.

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 8.40 a. M. on the date above stated.

Probably F.B. Causing nonarrest

(Signature) O O Moore M D

Paris Idaho
(Physician or midwife)

Address .....

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Filed Oct 16th 1930 Mrs. J. B. Skinner Registrar.
Per. Mrs. Arthur Hess.

MD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 10 1930

PLACE OF BIRTH
County of Bingham
City of Blackfoot
No. N. Oak St. St.
168 122-006 813
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185409

Registration District No. 121 State File No.
Prim. Registration District No. 1007 Local Registrar's No. 347

FULL NAME OF CHILD Alton Johnson
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	Oct. 22, 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo-Silvol 10%

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead Stillborn 1

FATHER	MOTHER
FULL NAME Lional Johnson	FULL MAIDEN NAME Mary Hatch
Residence (Usual place of abode) Blackfoot	Residence (Usual place of abode) Blackfoot
If non-resident, give place and State	If non-resident, give place and State
Color or race white Age at last Birthday 27 (Years)	Color or race white Age at last Birthday 24 (Years)
Birthplace Oklahoma (City and State or County)	Birthplace Heth Idaho (City and State or County)
Occupation Section Hand	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 12:45 P M. on the date above stated.

(Signature) J. D. Hampton M.D.
(Physician or midwife)
Address Blackfoot, Idaho

Filed Nov 7 1930 Mattalen E. Davis
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State Registration No. _____

Local Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____ (If a boy, substitute the word "Boy" for "Girl")

Sex of child _____ Twin, triplet, etc. _____ Number of child _____ Date of birth _____ (Month) (Day) (Year)

Number of child of this mother, including present birth _____ (If born alive but now dead) (If born alive and now living)

Was prophylactic was used to prevent Ophthalmia Neonatorum? _____

	FATHER	MOTHER
Full name		
Residence (Usual place of abode)		
Residence (Usual place of abode)		
If non-resident, give place and date		
Color or race	Age at last birthday (Years)	Age at last birthday (Years)
Birthplace		
Occupation		

Occupation _____ Birthplace (City and State or Country) _____ Residence (City and State or Country) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____

*Where there was no attending physician or midwife (see the father, householder, etc.), should make this report. A stillborn child is one that neither breathes nor shows any other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18 5400 A

REC... NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72299

Registration District No. 121

Primary Registration District No. 2144

Local Registrar's No. 154

PLACE OF DEATH

County of Bingham

City of Blackfoot Idaho

(No.) 204

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albany Johnson

(a) Residence. No. 13 & Oak St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): ✓

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years: ✓ Months: ✓ Days: ✓ If LESS than 1 day, ✓ hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Blackfoot Idaho

PARENTS

10. NAME OF FATHER: Lionel Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio City Ohio

12. MAIDEN NAME OF MOTHER: Mary Hakala

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Moreland Idaho

14. Informant: Leo Lionel Johnson

(Address): Blackfoot Idaho

15. Filed Oct. 27, 1930 Mrs Thalera E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 - 22 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: still born due to heavy lifting about 7 mo. premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. O. Hagaman M. D.

10 - 22, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wadsworth Cemetery — Date of Burial: Oct. 23 1930

20. Undertaker: Ostry. — Address: Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham

City of Shelley, Ida

No. ..... St.

(If born in hospital or institution give name.)

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 121 State File No. 185413

Prim. Registration District No. 2194 Local Registrar's No. 318

FULL NAME OF CHILD "Stillbirth"
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth: Oct (Month) 11 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 7 (a) Born alive and now living 4

Born alive but now dead 3 Stillborn 1

FATHER

FULL NAME C. J. Thornton

Residence (Usual place of abode) Shelley, Ida

If non-resident, give place and State

Color or race White Age at last Birthday 54 (Years)

Birthplace American Fork, Utah (City and State or County)

Occupation Laborer

MOTHER

FULL MAIDEN NAME Mary J. Russell

Residence (Usual place of abode) Shelley, Ida

If non-resident, give place and State

Color or race White Age at last Birthday 30 (Years)

Birthplace Gosselberry Utah (City and State or County)

Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born Alive~~ / Stillborn} at 1:45 P. M. on the date above stated.

(Signature) F. G. McNabb M.D.
(Physician or ~~midwife~~)

Address Shelley Idaho

Filed Oct. 20, 1930 Mrs Valentine Petrie
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WHITE PLAINLY WITH LINEADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of .....

City of .....

No. ..... St.

.....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	Number and in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month) (Day) (Year) 19....

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... stillborn .....

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME .....
Residence (Street and number)	Residence (Street and number) .....
Residence (City or town)	Residence (City or town) .....
Color or race ..... Age at last Birthday ..... (Years)	Color or race ..... Age at last Birthday ..... (Years)
Birthplace ..... (City and State or Country)	Birthplace ..... (City and State or Country)
Occupation	Occupation .....

(CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*)

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at ..... M. on the date above stated.

(Signature) .....

.....

(Physician or midwife)

Address .....

Filed ..... 19 .....

Registrar

*Where there was no attending physician or midwife, then the father, householder, or nurse should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72303

PLACE OF DEATH
County of Bingham
City of Shelley

CERTIFICATE OF DEATH
Registration District No. [illegible]
Primary Registration District No. [illegible]
Local Registrar's No. 100
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Thornton 204

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W.
5. Single, Married, Widowed, Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of Wife
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Still born

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wardville Ida

PARENTS

10. NAME OF FATHER C. J. Thornton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) American Fork Utah
12. MAIDEN NAME OF MOTHER Mary J. Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Grosebery Idaho

14. Informant C. J. Thornton
(Address) Shelley Idaho

15. Filed Oct 12 1930 Mrs Helen E. Cabrie
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Still born, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Received about one week before birth
Caused by a detached Placenta
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M. D.
Oct 11 1930 (Address) Shelley Ida

19. Place of Burial, ~~Cremation~~, or Removal Iona, Idaho. | Date of Burial Oct 12 1930

20. Undertaker None | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham

City of Blackfoot

No. R 7 Box 3 St.

(If born in hospital or institution give name.)

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185431

Registration District No. 121 State File No.

Prim. Registration District No. 3194 Local Registrar's No. 328

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes.	Oct 7 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead — Stillborn 1

FATHER		MOTHER	
FULL NAME	Torval Alfred Buttcane	FULL MAIDEN NAME	Ina Whitmill
Residence (Usual place of abode)	Blackfoot R #3	Residence (Usual place of abode)	Blackfoot R 3
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	22	Age at last Birthday (Years)	20
Birthplace (City and State or County)	Blackfoot	Birthplace (City and State or County)	Ida
Occupation	Salesman	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ **Stillborn** **at** 3.00 P.M. **on the date above stated.**

(Signature) W W Beck

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Blackfoot Ida

Filed Nov 5 1930 Mrs Hubert E. Patrick
Registrar.

[illegible] — [illegible] — [illegible] — [

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72287

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 127
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 146

200

2. FULL NAME Stillborn Buttcane

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 7, 1930

7. AGE: Years Stillborn | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Idaho

PARENTS

10. NAME OF FATHER Jorval Alfred Buttcane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Blackfoot Idaho
12. MAIDEN NAME OF MOTHER Ina Whitmill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Jarvil Buttcane
(Address) Blackfoot

15. Filed Oct. 8, 1930 Mrs Valeen E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 7, 1930
that I last saw h..... alive on Stillborn, 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Occiput Posterior
Instrument Delivery
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) W W Beck, M. D.
10/8, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery — Date of Burial: Oct 8 1930

20. Undertaker: E. T. Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 10 1930

PLACE OF BIRTH

County of Bingham

City of Thomas

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185435

Registration District No. 121 State File No. .....

Prim. Registration District No. 9194 Local Registrar's No. 324

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	Oct. 3 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 10 (a) Born alive and now living 7

Born alive but now dead ..... Stillborn 3

FATHER	MOTHER
FULL NAME Wm. J. Van Orden	FULL MAIDEN NAME Hazel May Baker
Residence (Usual place of abode) Thomas	Residence (Usual place of abode) Thomas
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 43 (Years)	Color or race White Age at last Birthday 37 (Years)
Birthplace Utah (City and State or County)	Birthplace Utah (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ **Stillborn** **at** 8:45 p. M. **on the date above stated.**

(Signature) W W Beck

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Blackfoot Ida

Filed Nov. 5 1930 Mrs Walter E Olive

Registrar.

[illegible]

NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72292

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 141

304

2. FULL NAME Stillborn Van Orden

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): Oct. 3, 1930

7. AGE: Years Stillborn | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Ida

PARENTS
10. NAME OF FATHER: William J. Van Orden
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Hazel May Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Wm. J. Van Orden
(Address): Blackfoot Ida RR # 2

15. Filed: Oct 6, 1930 Mrs. Helen E. Cutrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3, 1930, to Oct 3, 1930
that I last saw him alive on Stillborn
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Prolapsed Cord
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
Oct 4, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside-Thomas Cem | Date of Burial: 10/4/30
20. Undertaker: Modern Mortuary | Address: Bfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185456

PLACE OF BIRTH
County of Bonner
City of Sandpoint, Ida.
No. St.
Parnell
(If born in hospital or institution give name.)

Registration District No. 76 State File No.
Prim. Registration District No. 2155 Local Registrar's No. 142

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Oct. 14 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate

Number of child of this mother, including present birth 1st. (a) Born alive and now living
Born alive but now dead Stillborn 1

FATHER	MOTHER
FULL NAME Oliver A. Petersen	FULL MAIDEN NAME Rachel Caroline Jacobson
Residence (Usual place of abode) Sandpoint, Ida.	Residence (Usual place of abode) Sandpoint, Ida
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 35 (Years)	Color or race White Age at last Birthday 20 (Years)
Birthplace Jackson Co. Wisconsin (City and State or County)	Birthplace Eau Claire, Wisconsin (City and State or County)
Occupation Rancher	Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9 P. M. on the date above stated.

(Signature) Floyd G. Wegale M.D.
(Physician or midwife)

Address Sandpoint Idaho

Filed Nov. 4 1930 [redacted] Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Place _____ Registration District No. _____ Local Registrar's No. _____

CHILD'S NAME OR OTHER IDENTIFICATION _____

(If stillborn, substitute the word "Stillborn" for name of child)

Sex _____ Twin, triplet, etc. (or single) _____ Number in order of birth _____ Legitimate or illegitimate _____ Date of birth _____ (Month) _____ (Day) _____ (Year) 19__

Drops or other prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child in this mother, including present child _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

FATHER

FULL NAME _____ MOTHER'S FULL NAME _____

Residence (usual place of abode) _____

If non-resident give place and state _____

Color or race _____ Age at last birthday _____ (years)

Birthplace (city or town and state or country) _____

Occupation _____

MOTHER

Color or race _____ Age at last birthday _____ (years)

If non-resident give place and state _____

Residence (usual place of abode) _____

Birthplace (city and state or country) _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at the place and date stated.

(Signature) _____

(Physician or midwife)

Address _____

Where there was no attending physician or midwife, then the father, householder, etc., should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECE NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72315

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

2. FULL NAME Infant Peterson

(a) Residence. No. Sandpoint RFD #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 14, 1930

7. AGE: Years: Stillborn; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Ida

PARENTS
10. NAME OF FATHER Oliver Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc
12. MAIDEN NAME OF MOTHER Rachel Jacobson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc

14. Informant Oliver Peterson
(Address) Sandpoint RFD #1

15. Filed Oct 15, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stillborn, 19..
that I last saw h.. alive on .., 19..
and that death occurred, on the date stated above, at .. m.
The CAUSE OF DEATH* was as follows:
Difficult delivery
9 months gestation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Malposition
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Floyd G. Wendle, M. D.
Oct 15, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	10/15 1930
20. Undertaker	**Address**
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and **children,** not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Canyon

City of Nampa

No. R. 2 St.

(If born in hospital or institution give name.)

NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 185513

613 103 014 556

Registration District No. 7 State File No.

Prim. Registration District No. 2006 Local Registrar's No. 57

FULL NAME OF CHILD Stillbirth Waldvogel.

(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child	Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month) (Day) (Year)
Male		yes	10 - 3 - 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 10%

Number of child of this mother, including present birth 3 (a) Born alive and now living 3

Born alive but now dead one Stillborn one

FATHER	MOTHER
FULL NAME Clarence Franklin Waldvogel	FULL MAIDEN NAME Hertha Bea Newland
Residence (Usual place of abode) RR Nampa	Residence (Usual place of abode) R. 2 Nampa
If non-resident, give place and State	If non-resident, give place and State
Color or race W. Age at last Birthday 29 (Years)	Color or race W. Age at last Birthday 26 (Years)
Birthplace Warrensburg Mo. (City and State or County)	Birthplace Anson Kan. (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9:30 A. M. on the date above stated.

(Signature) J. C. Horton

M. D.

(Physician or midwife)

Address Nampa Idaho

Filed 11-8 1930 Bertha Conway

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Rec'd DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72697

PLACE OF DEATH
County of Canyon
City of Nampa R. 2.

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

206

2. FULL NAME Stillborn Waldvogel

(a) Residence. No. Nampa R. 2 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓
6. DATE OF BIRTH (month, day and year): ✓
7. AGE Years: ✓ Months: ✓ Days: ✓ If LESS than 1 day, ✓ hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓
9. BIRTHPLACE (city or town) (State or country): Nampa R. 2,

PARENTS
10. NAME OF FATHER: Clarence Franklin Waldvogel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Warrensburg, Mo.
12. MAIDEN NAME OF MOTHER: Letha Bea Newland.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Anson Kan.

14. Informant: Clarence Waldvogel,
(Address) Nampa R. 2.

15. Filed 10-4 1930 Letha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on 10-3, 1930, to ....., 19..
that I last saw him alive on 10-3 1930
and that death occurred, on the date stated above, at 9:30 A. m.
The CAUSE OF DEATH* was as follows:

Premature birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) J. Porter, M. D.
10-4, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa R. 2. Date of Burial: 10-3 1930

20. Undertaker: C. F. Waldvogel Address: Nampa R. 2.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED OCT 31 1930

County of Cassia

City of Burley

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185559

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	Sept 3 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo Silver 5%

Number of child of this mother, including present birth ..... (a) Born alive and now living 1

Born alive but now dead ..... Stillborn 1

FATHER		MOTHER	
FULL NAME	G. M. Conner	FULL MAIDEN NAME	Bessie Holest
Residence (Usual place of abode)	Burley Idaho	Residence (Usual place of abode)	Burley Ida
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	25	Age at last Birthday (Years)	24
Birthplace (City and State or County)	La Grande Oregon	Birthplace (City and State or County)	Brigham City Utah
Occupation	Mechanic Park Garage	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Premature~~ Stillborn} at 10:30 A. M. on the date above stated.

Premature (Signature) G. H. Cooper M.D.

Physician & Surgeon
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Burley Idaho

Filed 10-15 1930 F. H. Cutler
Registrar.

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72375

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

106

2. FULL NAME Baby Conner

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept.3 1930

7. AGE: Years ... Months: Still Days: Born If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Charles M Conner

11. BIRTHPLACE OF FATHER (city or town) La Grande
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Bessie Holst

13. BIRTHPLACE OF MOTHER (city or town) Brigham City
(State or County) Utah.

14. Informant C.M.Conner
(Address) Burley Ida

15. Filed 10-Bill-, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept.3 1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ ....., 19....., to ✓ ....., 19.....
that I last saw him ✓ alive on ✓ ....., 19.....
and that death occurred, on the date stated above, at 10:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

— Dead born —

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature birth

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) G. H. Cooper M. D.
Sept. 19 ..., 1930 (Address) Burley Ida.

19. Place of Burial, Cremation, or Removal: Burley Ida — Date of Burial: Sept. 4 1930

20. Undertaker: D.E.Johnson — Address: Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 12 1930

County of Idaho

City of Winona

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185671

Registration District No. 105 State File No. .....

Prim. Registration District No. 2183 Local Registrar's No. 55

FULL NAME OF CHILD Yvonne Marie Orr (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
F				yes	Oct. 25 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead ..... Stillborn .....

FATHER	MOTHER
FULL NAME Harvey Orr	FULL MAIDEN NAME Viola Josephine Johnson
Residence (Usual place of abode) Winona, Idaho	Residence (Usual place of abode) Winona, Idaho
If non-resident, give place and State	If non-resident, give place and State .....
Color or race W. Age at last Birthday 28 (Years)	Color or race W. Age at last Birthday 23 (Years)
Birthplace So. Dakota (City and State or County)	Birthplace Green Creek, Idaho (City and State or County)
Occupation Farming	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {[redacted] / ~~stillborn~~} at 6 A. M. on the date above stated.

(Signature) Wesley F. Orr M.D.

(Physician or midwife)

Address Cottonwood Idaho

Filed 10/31 1930 W. F. Orr Jr. D.B.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 72423
Registered No. 79

1. PLACE OF DEATH
County of Idaho
City of Winona (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Yvonne Marie Orr (Stillborn)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: October 25 1930 (Month) (Day) (Year)

7. AGE: ✓ Yrs. ✓ Mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Winona, Idaho

10. NAME OF FATHER: Harvey Orr

11. BIRTHPLACE OF FATHER (State or Country): Dakota

12. MAIDEN NAME OF MOTHER: Viola Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey Orr
(Address) Winona, Ida.

15. Filed 10/25 1930 H. F. Orr J.P.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2/6
..... 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Stillbirth due to version in shoulder presentation. 12 lb. baby.
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.
10/25 1930 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Winona Ida. DATE OF BURIAL: 10-25 1930

20. UNDERTAKER: Harvey Orr ADDRESS: Winona

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility,' ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185719

PLACE OF BIRTH

County of Kootenai

City of Coeur d'Alene

No. 807 - C St.

415 706 028 386

(If born in hospital or institution give name.)

Registration District No. 1050 State File No.

Prim. Registration District No. 30 Local Registrar's No. 163

FULL NAME OF CHILD Stillbirth Davis (Five months)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
Male				yes	Sept.	6	1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Lem L. Davis	FULL MAIDEN NAME	Irma Thomley
Residence (Usual place of abode)	CDA	Residence (Usual place of abode)	CDA
If non-resident, give place and State		If non-resident, give place and State	
Color or race	W. Age at last Birthday 49 (Years)	Color or race	Age at last Birthday 35 (Years)
Birthplace (City and State or County)	Lumen, Iowa	Birthplace (City and State or County)	Mountain Home, Idaho
Occupation	Laborer	Occupation	None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9:30 A. M. on the date above stated.

(Signature) Harold T. Anderson
(Physician or midwife)

Address Coeur d'Alene Ida.

Filed 9/29 1930 N. J. Sturgis
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

[illegible]

[illegible]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED OCT 17 1930

PLACE OF BIRTH

County of Lemhi

City of Baker

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 41 State File No. 185738

Prim. Registration District No. 216 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male			Yes	Aug 11 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth Two (a) Born alive and now living One

Born alive but now dead ..... Stillborn One

FATHER	MOTHER
FULL NAME Jas A Owens	FULL MAIDEN NAME Nina Fry
Residence (Usual place of abode) Baker	Residence (Usual place of abode) Baker
If nonresident, give place and State	If nonresident, give place and State .....
Color or race wh Age at last Birthday 24 (Years)	Color or race wh Age at last Birthday 23 (Years)
Birthplace Ida (City and State or Country)	Birthplace ~~Baker~~ Ida (City and State or Country)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 12 M. on the date above stated.

(Signature) F S Wright MD

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Salmon

Filed Oct 1 1930 Chas Ballamy Registrar.

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71775

- PLACE OF DEATH
County of Lincoln
City of Baker

Registration District No. 4
Primary Registration District No. 2116

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Stillbirth

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Baker Idaho

PARENTS

10. NAME OF FATHER Jess Owens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wyoming
12. MAIDEN NAME OF MOTHER Nina Fry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma

14. Informant A. W. Fry
(Address) Baker Ida

15. Filed 9/10, 1930 Cho Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 11th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 11, 1930
that I last saw h alive on , 19
and that death ~~occurred on the~~ date stated above, at 12 hrs m.
The CAUSE OF DEATH* was as follows:
Stillborn
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Not known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F J Wright, M. D.
Aug 14, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial 8/12/1930
20. Undertaker: M C Moeller — Address: Salmon Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185749

PLACE OF BIRTH
County of Lewis
City of Winchester
No. ..... St. .....
Winchester Hospital
(If born in hospital or institution give name.)

Registration District No. 60 State File No. .....
Prim. Registration District No. 217 Local Registrar's No. 36

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Oct. (Month) 25 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Ni

Number of child of this mother, including present birth None (a) Born alive and now living None
Born alive but now dead none Stillborn one

FATHER
FULL NAME Chas. W. Hunter
Residence (Usual place of abode) Winchester, Idaho
If non-resident, give place and State .....
Color or race White Age at last Birthday 23 (Years)
Birthplace Turtlelake, Wis. (City and State or County)
Occupation Lumberman

MOTHER
FULL MAIDEN NAME Mis Laura Prentis
Residence (Usual place of abode) Winchester, Ida
If non-resident, give place and State .....
Color or race White Age at last Birthday 21 (Years)
Birthplace Asotin, Wash. (City and State or County)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 8:30 A.M. on the date above stated.

(Signature) A B Halliday, M.D.
(Physician or midwife)

Address Winchester, Idaho

Filed 11/4 1930 R G Dunn
Registr

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72487

PLACE OF DEATH

County of Lewis

City of Winchester

Registration District No. 60

Primary Registration District No. 29

Local Registrar's No. 19

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DOA

2. FULL NAME Stillbirth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 25, 1930

7. AGE: Years | Months | Days: Born dead | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Winchester, Ida.

PARENTS

10. NAME OF FATHER Chas. W. Hunter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Turtle Lake, Wis.

12. MAIDEN NAME OF MOTHER Laura Prentis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ascotin Wash.

14. Informant Chas. W. Hunter
(Address) Winchester, Ida.

15. Filed 11/4, 1930 P G Duncan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1930, to Oct. 25, 1930 that I last saw ~~he~~ alive on Stillborn, 19..... and that death occurred, on the date stated above, at 8:30 A.m.

The CAUSE OF DEATH* was as follows:

Stillbirth due to Eclampsia of the mother

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) A.B. Halliday, M. D.

Oct. 25, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial~~, Cremation, ~~or Removal~~: Winchester, Ida | Date of Burial: Oct. 25 1930

20. Undertaker: none | Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases **resulting from childbirth or** miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull**, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Minidoka

City of Rupert

No. ..... St.

(If born in hospital or institution give name.)

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185779

Registration District No. 19 State File No.

Prim. Registration District No. 2010 Local Registrar's No. 157

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? | and | Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth Oct 14 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Nes Silver nitrate

Number of child of this mother, including present birth 10 (a) Born alive and now living 8

Born alive but now dead | Stillborn |

FATHER	MOTHER
FULL NAME Francis Mable	FULL MAIDEN NAME Gladys Fitzsmith
Residence (Usual place of abode) Rupert	Residence (Usual place of abode) Rupert
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 41 (Years)	Color or race White Age at last Birthday 40 (Years)
Birthplace Tooele Utah (City and State or County)	Birthplace Utah (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ Stillborn} at 3:20 P.M. on the date above stated.

(Signature) E. W. Elmore
MD
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Rupert

Filed 11-8 1930 E. W. Elmore
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ Birth No. _____

Place of birth: Hospital or Institution _____ Plac. Registration District No. _____ Local Registrar's No. _____
(Give name)

FULL NAME OF CHILD _____
(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child	Twin, Triplet, or other	Number in order of birth	Legitimate?	Date of birth	
		(Mark "1" if only one or first born twin or triplet)		(Month)	(Day)	19 (Year)

Was prophylactic eye wash used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

FATHER		MOTHER
FULL NAME		FULL MAIDEN NAME
Residence (Usual place of abode)		Residence (Usual place of abode)
If non-resident, give place and State		If non-resident, give place and State
Color or race	Age at last Birthday (Years)	Color or race Age at last Birthday (Years)
Birthplace (City and State or Country)		Birthplace (City and State or Country)
Occupation	Occupation	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive / stillborn at _____ on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____ 19 _____

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

FORM V. S. No. 5-25 M. 1-19. NOV 6 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. 19
Primary Registration District No. 2213
(No. ..... St.)

State File No. 72498
Local Registrar's No. 47

1. PLACE OF DEATH

County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn Mobile

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX He

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6. DATE OF BIRTH Oct. (Month) 16 (Day) 1930 (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 0 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Stillborn
(b) General nature of industry, business or establishment in which employed (or employer) –

9. BIRTHPLACE (State or Country) Rupert, Idaho

10. NAME OF Father Francis Mobile

11. BIRTHPLACE OF FATHER (State or Country) Nephi Utah

12. MAIDEN NAME OF MOTHER Gladys Titcomb

13. BIRTHPLACE OF MOTHER (State or Country) Nephi, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis Mobile
(Address) Rupert, Idaho

15.
Filed Nov. 4 1930 E. V. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16 1930 to ..... 19....,
that I last saw him alive on Oct. 16 1930,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Stillborn

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Asphyxia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. V. Elmore M. D.
11-4 1930 (Address) Rupert, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ..... 19....

20. UNDERTAKER | **ADDRESS**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Nez Perce

City of

No. 432-106 035-155 St.

Lewiston Orchards

(If born in hospital or institution give name.)

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 9695 State File No. 185801

Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD /

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male				yes	Oct 6 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Dennis McKay	FULL MAIDEN NAME	Lura Jenkins
Residence (Usual place of abode)	Myrtle Idaho	Residence (Usual place of abode)	Same
If non-resident, give place and State		If non-resident, give place and State	
Color or race	W.	Color or race	White
Age at last Birthday (Years)	31	Age at last Birthday (Years)	16
Birthplace (City and State or County)	Idaho	Birthplace (City and State or County)	Washington
Occupation	Laborer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 4:30 P. M. on the date above stated.

(Signature) J. M. Tyle M.D.

Physician

(Physician or midwife)

Address Lewiston, Idaho

Filed 11-1 1930 J. M. Tyle

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NOTE B—In case of twins, triplets, etc., the information should be given for each child in the order of birth, beginning with the first born.

NOTE C—THIS IS A DIPLOMATIC COPY OF THE ORIGINAL RECORD. ALL ABBREVIATIONS, PUNCTUATION, SPELLING, CAPITALIZATION, ETC., ARE REPRODUCED EXACTLY AS THEY APPEAR IN THE ORIGINAL RECORD.

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

FORM OF CERTIFICATE OF BIRTH

(Registration District No.

Form. Registration District No.

(Sub-district

(Registration District

(Sub-district

FIRST NAME OF CHILD

(If stillborn, substitute the word "stillborn" in the place of the name.)

Sex of child

Twin, triplet or other plural birth

Number of child in order of birth

Surname and Christian name of father

Date of birth (month)

Place of birth

(Use separate line for each child.)

Was hospitalization used in present Quintuplets Confinement?

Number of child of this mother including present birth

a) Have alive and now living

b) Have alive but now dead

FATHER

MOTHER

Residence (street and house number)

Residence (town or place)

Residence (county)

Residence (state or country)

Color or race

Age at last birthday (years)

Age at last birthday (years)

Birthplace

(Town and state or country)

(Town and state or country)

Occupation

Occupation

Nationality

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Born alive

I hereby certify that I attended the birth of this child, who was born alive at the place above stated.

(Signature)

(Professional title)

Address

Filed ..... 19..

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Ada

City of Malad

No. ..... St.

Community Hospital
(If born in hospital or institution give name.)

Registration District No. 26 State File No. 185819

Prim. Registration District No. 2069 Local Registrar's No. 134

FULL NAME OF CHILD Stillborn Ward
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Female

Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births)

Legitimate? Yes

Date of birth: Oct 21 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME: Jess L. Ward Jr.	FULL MAIDEN NAME: Delila Jones
Residence (Usual place of abode): Malad	Residence (Usual place of abode): Malad
If nonresident, give place and State:	If nonresident, give place and State:
Color or race: white Age at last Birthday: 32 (Years)	Color or race: white Age at last Birthday: 26 (Years)
Birthplace: Rockford, Ida (City and State or Country)	Birthplace: Malad, Ida. (City and State or Country)
Occupation: Farmer	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / Stillborn at 4:30 a. M. on the date above stated.

(Signature) V. O. Garst
Physician
(Physician or midwife)

Address Malad Idaho.

Filed 10-31 1930 J. M. Kruse
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

REC... NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72522

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 40

(No.) 306
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born Ward

(a) Residence. No. Malad Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 21-30

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malad

PARENTS
10. NAME OF FATHER Jess L Ward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad Idaho
12. MAIDEN NAME OF MOTHER Delila Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Malad

14. Informant Jess L Ward
(Address) Malad Idaho.

15. Filed 10-31, 1930. J. M. Nerus Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Stillborn.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. B. Grant, M. D.
Oct. 22, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Cem. | Date of Burial: Oct. 31 1930

20. Undertaker: J. Guy Hanna | Address: Malad Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and t death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in montl

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epiden cerebrospinal meningitis"); **Diphtheria** (avoid use "Croup"); **Typhoid fever** (never report "Typhoid Pne monia"); **Lobar pneumonia; Bronchopneumonia** ("Pne monia," unqualified, is indefinite); **Tuberculosis of lun meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., ... (name origin; "Cancer" is less definite; av use of "Tumor" for malignant neoplasms; **Measl Whooping cough; Chronic valvular heart disease; Chro interstitial nephritis, etc.** The contributory (secondary intercurrent affection need not be stated unless importa Examples: **Measles** (disease causing death), **29 ds.; Br chopneumonia** (secondary), **10 ds.** Never report me symptoms or terminal conditions, such as "Asthenia "Anaemia" (merely symptomatic), "Atrophy," "Collaps "Coma," "Convulsions," "Debility," ("Congenital," "S nile," etc.), "Dropsy," "Exhaustion," "Heart Failur "Hemorrhage," "Inanition," "Marasmus," "Old ag "Shock," "Uraemia," "Weakness," etc., when a defin disease can be ascertained as the cause. Always qual as "PUERPERAL **septicemia,**" "PUERPERAL **perit itis,**" etc. all diseases resulting from childbirth or misc riage. State cause for which surgical operation was u dertaken. For VIOLENT DEATHS, state MEANS (INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as **probably** such, if impossible to termine definitely. Examples: **Accidental drownir struck by railway train—accident; Revolver wound head—homicide; Poisoned by carbolic acid—probably s cide.** The nature of the injury, as fractured skull, and c sequences (e. g. **sepsis, tetanus**) may be stated under head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attenc the deceased and it is probable that death was due to u lawful or suspicious means, the case should be referred the Coroner for investigation and statement of the cau of death; other deaths than above without medical atte ance should be referred to the Health Officer (if a phy cian), but when there is no such health officer, and o in such cases, the local registrar may make the return up the information of relatives or friends of the deceas having adequate knowledge of the facts.

Do not accept a certificate of death signed only by midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Oneida

City of Stone

No. ..... St.

(If born in hospital or institution give name.)

NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 26 State File No. 185829

Prim. Registration District No. 2069 Local Registrar's No. 114

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? Yes | Date of birth Sept. 4 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Stillbirth

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn 0

FATHER	MOTHER
FULL NAME Alfred Louis Dafey	FULL MAIDEN NAME Trilba Sled
Residence (Usual place of abode) Stone Ida	Residence (Usual place of abode) Stone
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 35 (Years)	Color or race White Age at last Birthday 24 (Years)
Birthplace Stone Ida. (City and State or Country)	Birthplace Clinton Utah (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / Stillborn} at 6 P. M. on the date above stated.

(Signature) Ella Sandleigh Bms

Physician

(Physician or midwife)

Address Lewiston Utah

Filed 10-31 1930 J. M. Kunz

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

185895

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. ..... St. T. F. Co + Gen. Hosp.

(If born in hospital or institution give name.)

Registration District No. 37 State File No.

~~Prim.~~ Registration District No. 2085 Local Registrar's No. 139

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female.			Yes.	Oct. 1 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate

Number of child of this mother, including present birth 2 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 0

FATHER	MOTHER
FULL NAME Herman Charles Stanfield	FULL MAIDEN NAME Ruby Ellen Claycomb
Residence (Usual place of abode) Buhl, Idaho.	Residence (Usual place of abode) Buhl. Idaho.
If non-resident, give place and State	If non-resident, give place and State
Color or race W. Age at last Birthday 28 (Years)	Color or race W Age at last Birthday 25 (Years)
Birthplace Versailles Indiana (City and State or County)	Birthplace Johnstown Colo. (City and State or County)
Occupation Farmer	Occupation Home wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} **at** 6.40 P. M. **on the date above stated.**

(Signature) Geo. Jennings

(Physician or midwife)

Address Buhl Idaho

Filed Nov 16 1930 Elizabeth J. Smith Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

[illegible]

[illegible]

NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72559

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 172

2. FULL NAME Jennie Louise Stanfield

(a) Residence No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 0 Months 0 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): "
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Twin Falls Ida

PARENTS
10 NAME OF FATHER: Herman Stanfield
11 BIRTHPLACE OF FATHER (city or town) (State or country): Indian
12 MAIDEN NAME OF MOTHER: Ruby Claycomb
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Colorado.

14 Informant: W. J. Stanfield
(Address): Buhl Ida R.F.D.5

15 Filed Oct. 16, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 6 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10-6-, 1930, to 10-6-, 1930, that I last saw h. ~~sa~~ ~~alive~~ on Not living, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
1. Immature - about 6½ mos.
Detached placenta with hemorrhage
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Geo Jenning, M. D.
10-7-, 1930 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~: Twin Falls Ida
Date of Burial: 10-8 1930

20. Undertaker: White Mortuary
Address: Twin Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

442-223 042-168

RECEIVED NOV 6 1930

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. 752-2nd Ave East

Private Sanatarium

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S**

Registration District No. 37 State File No. 18590

Prim. Registration District No. 1085 Local Registrar's No. 422

FULL NAME OF CHILD Barbara Elizabeth Duke

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? ____ (To be answered only in event of plural births) | and | Number in order of birth ____ | Legitimate? Yes | Date of birth Sept. 22 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ____

Number of child of this mother, including present birth One (a) Born alive and now living no born dead

Born alive but now dead Born dead Stillborn ____

FATHER	MOTHER
FULL NAME Jesse Lynn Duke	FULL MAIDEN NAME Hallene Viola Johnson
Residence (Usual place of abode) Twin Falls	Residence (Usual place of abode) ____
If nonresident, give place and State ____	If nonresident, give place and State Twin Falls
Color or race White Age at last Birthday 23 (Years)	Color or race White Age at last Birthday 23 (Years)
Birthplace Santaquin Utah (City and State or Country)	Birthplace Mountain Pleasant Utah (City and State or Country)
Occupation Operator news	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR ~~MIDWIFE~~*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 2:45 P. M. on the date above stated.

(Signature) E. Lamb

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Twin Falls Idaho

Filed Oct. 29 1930 Elizabeth J. Smith Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72100

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 160

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbara L. Duke

(a) Residence. No. 103 Reed apt. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 22 1930.

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Still Born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: J. J. Duke

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hallene Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: J. J. Duke
(Address): 103 Reed apt. T. Falls

15. Filed Sept 27 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to , 19
that I last saw h. Still born , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Dont know cause.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. E. Lamb M. D.
Sept 22 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Sept 23 1930

20. Undertaker: L. G. Duke — Address: Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 6 1930

County of Twin Falls

City of Twin Falls

No. ..... St.

T. F. Co. Mem. Hosp. Registration District No. 37 State File No. 25933

(If born in hospital or institution give name.)

Prim. Registration District No. 2085 Local Registrar's No. 451

FULL NAME OF CHILD Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Male				yes	Oct. 29 19 30 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Harold M. Miller	FULL MAIDEN NAME	Effie May Allen
Residence (Usual place of abode)	Hansen	Residence (Usual place of abode)	Hansen
If non-resident, give place and State		If non-resident, give place and State	
Color or race	W.	Color or race	W.
Age at last Birthday (Years)	19.	Age at last Birthday (Years)	19.
Birthplace (City and State or County)	Berryville Ark.	Birthplace (City and State or County)	Berryville Ark.
Occupation	Labor.	Occupation	Home wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / **Stillborn** **at** 8 13 a. **M. on the date above stated.**

(Signature) A. A. Woolhery

Filer Idaho

(Physician or ~~Midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Twin Falls, Idaho

Filed Nov. 1 1930 Elizabeth J. Smith

Registrar.

RECE D NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72547

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

(No. County Gen. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 187

208

2. FULL NAME Baby Miller

(a) Residence. No. Hansen, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls
(State or country)

PARENTS

10. NAME OF FATHER Harold M. Miller

11. BIRTHPLACE OF FATHER (city or town) Ark.
(State or Country)

12. MAIDEN NAME OF MOTHER Effa Allen

13. BIRTHPLACE OF MOTHER (city or town) Ark.
(State or Country)

14. Informant Horald M. Miller
(Address) Hansen, Idaho.

15. Filed Nov/5/30 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 29Th. 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 30, to Oct 29, 30
that I last saw h~~im~~ alive on, 19
and that death occurred, on the date stated above, at 813 AM m.

The CAUSE OF DEATH* was as follows:

Still born
Premature
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. G. Lawhorn M. D.
10/29 19 30 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida.	Oct. 30 19 30

20. Undertaker	Address
F.H. Grossman	Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 1 1980

PLACE OF BIRTH

County of Washington

City of Weiser

No. 5-R St.

593-202-044-313

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 86 State File No. 185960

Prim. Registration District No. 1010 Local Registrar's No. 35

FULL NAME OF CHILD Frankie Lou. Nichols

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Oct. 2nd 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth One (a) Born alive and now living None

Born alive but now dead None Stillborn None

FATHER	MOTHER
FULL NAME Frank Nichols	FULL MAIDEN NAME Ofa Calkins
Residence (Usual place of abode) Weiser Ida	Residence (Usual place of abode) Weiser Ida
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 27 (Years)	Color or race White Age at last Birthday 23 (Years)
Birthplace Idaho (City and State or County)	Birthplace Weiser (City and State or County)
Occupation R. R. Motor man	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Alive~~ Stillborn at 8. P. M. on the date above stated.

(Signature) W. R. Hamilton
Physician
(Physician or midwife)

Address Weiser Idaho

Filed Oct 5 1930 W. R. Hamilton M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

"FATHER" BILL

DEPARTMENT OF PUBLIC HEALTH

BUREAU OF VITAL STATISTICS

STATE OF ILLINOIS

Registration District No. _____ State File No. _____

Place of Birth: County _____ Township _____ City _____

Ward _____ Village _____

Full Name of Child _____

Sex _____ Color or Race _____ Legitimate _____ Illegitimate _____

Date of Birth _____ Hour _____

Number of child of this mother, including present birth _____ Now living _____ Now dead _____

Number other children of this mother now living _____ Number other children of this mother now dead _____

FATHER

Full Name _____

Color or Race _____ Age at last Birthday _____ Birthplace _____

Occupation _____ Business or industry _____

MOTHER

Maiden Name _____

Color or Race _____ Age at last Birthday _____ Birthplace _____

Occupation _____ Business or industry _____

Place of Residence: Street _____ City or Village _____ County _____

Was mother married? _____ Was mother married at time of birth? _____

Was mother married at time of conception? _____ Was mother married at time of death? _____

Was prophylactic used to prevent Ophthalmia Neonatorum? _____

Number of children of this mother including present birth _____ Now living _____ Now dead _____

Number other children of this mother now living _____ Number other children of this mother now dead _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ on the date above stated.

(Signature)

(Physician or midwife)

Address _____

Title _____

Where there was no attending physician or midwife, then the father, householder, or other person must make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

REC NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72582

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Frankie Lou Nichols

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wt
5. Single, Married, Widowed, or Divorced (write the word): Stillborn

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct. 2nd 1930

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Weiser
(State or country) Idaho

PARENTS
10. NAME OF FATHER Frank Nichols
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Opal Colkins
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mum

14. Informant Frank Nichols
(Address) Weiser Idaho

15. Filed Oct. 13, 1930 W. R. Hamilton
Registrar
M N M

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1930, to ....., 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Stillborn
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. R. Hamilton, M. D.
Oct. 3rd, 1930. (Address) Weiser Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 10-3-1930

20. Undertaker: L. C. Northam — Address: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

185960 N

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

289 112 893 864

DEC 3 1930

PLACE OF BIRTH

County of Bannock

City of Bancroft

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

186031

Registration District No. 84 State File No. .....

Prim. Registration District No. 2161 Local Registrar's No. 839

FULL NAME OF CHILD (Stillborn) Byington

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate	Date of birth (Month) (Day) (Year)
				Yes	Nov 12, 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 6 (a) Born alive and now living 3

Born alive but now dead ..... Stillborn 3

FATHER	MOTHER
FULL NAME Roy L. Byington	FULL MAIDEN NAME Florence Housely
Residence (Usual place of abode) Bancroft	Residence (Usual place of abode) Bancroft
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday 31 (Years)
Birthplace Idaho (City and State or Country)	Birthplace Utah (City and State or Country)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / ~~Stillborn~~ } Stillborn **at** 3:30 P. M. **on the date above stated.**

(Signature) G. Goit M.D.

(Physician or midwife)

Address Bancroft Idaho

Filed Dec 1 1930 Mrs. L. G. Fel

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72620

PLACE OF DEATH

County of Bannock

City of Bancroft Ida

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

(No.)

Local Registrar's No. 194

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2040

2. FULL NAME Byington

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 12 1930

7 AGE Years Months Days Stillborn or If less than 24 hrs. ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bancroft Ida

PARENTS

10 NAME OF FATHER Roy L. Byington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho

12 MAIDEN NAME OF MOTHER Florence Housley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Roy L. Byington

(Address) Bancroft Ida

15 Filed Dec 1, 1930 Mrs G. G. Fit
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 12, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Stillbirth, 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Stillbirth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G G Fit M. D.

Nov 13, 1930 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Lava Hot Springs

Date of Burial: Nov 13 1930

20. Undertaker: Hadi...one

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. 1212 E Clark St.

St Anthony

(If born in hospital or institution give name.)

RECEIVED DEC 8 1930

296-326
003-359

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

186040

Registration District No. 28 State File No.

Prim. Registration District No. 2141 Local Registrar's No. 10109

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? | and | Number in order of birth (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Nov 26 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth [redacted] (a) Born alive and now living 2

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME James L Brown	FULL MAIDEN NAME Ella Clifford
Residence (Usual place of abode) Pocatello	Residence (Usual place of abode) Pocatello
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 39 (Years)	Color or race White Age at last Birthday 35 (Years)
Birthplace Utah (City and State or Country)	Birthplace Idaho (City and State or Country)
Occupation Railroad Employ	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 12 noon M. on the date above stated.

(Signature) Dr C P Swan

Physician

(Physician or midwife)

Address Pocatello Idaho

Filed 12/1 1930 J H Fanning

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
Local Registration District No. _____ Local Registration No. _____

(If stillborn, substitute the word stillbirth for the word birth)

(To be answered only in event of dual birth)

When prophylactic was used to prevent ophthalmia "neonatorum"

Number of child of this mother including present birth _____ (a) Born alive at this birth _____

Twin, triplet, etc. born alive at a prior birth _____

CHILD	FATHER	MOTHER
FULL NAME		
MAIDEN NAME		
Residence (Usual place of abode)		
Residence (Place where you live)		
Color or race	Age at last birthday (years)	Age at last birthday (years)
Birthplace (City and State or country)		
Occupation		
Birthplace		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ on the date above stated.

(Signature)

(Professional title)

Address _____

Filed _____ 19__

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72622

PLACE OF DEATH
County of Bannock
City of Pocatello

CERTIFICATE OF DEATH
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5948
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Baby Brown "Brown"
(a) Residence. No. 1212 E Clark St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 11/26/38

7. AGE Stillborn

Years	Months	Days	If LESS than 1 day,
			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello

PARENTS

10. NAME OF FATHER Leo L. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake Utah
12. MAIDEN NAME OF MOTHER Ella Cobb
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Grant Idaho

14. Informant Leo L. Brown
(Address) Pocatello

15. Filed 11/27 1938 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26 1938
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/26 1938 to 11/26 1938
that I last saw h.. alive on Stillborn 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
11/26/38 19 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Rigby Ida — Date of Burial 11/27 1938

20. Undertaker J. S. Brown — Address Pocatello
Father

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, **state MEANS OF** INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

145-113 P03-291 DEC 8 1930

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. 1229 N. Hayes St.

Pocatello Ga. Idaho

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

186059

Registration District No. 28 State File No.

Prim. Registration District No. 216 (Local Registrar's No. 10,090

FULL NAME OF CHILD Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	11 - 13 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth X (a) Born alive and now living X

Born alive but now dead Stillborn 1

FATHER

FULL NAME Harry Wm. Amundsen

Residence (Usual place of abode) 1229 N. Hayes St.

If non-resident, give place and State

Color or race W Age at last Birthday 31 (Years)

Birthplace Pocatello, Ida. (City and State or County)

Occupation Q. Yard R.R.

MOTHER

FULL MAIDEN NAME Evelyn Crane

Residence (Usual place of abode) 1229 N. Hayes

If non-resident, give place and State

Color or race W Age at last Birthday 28 (Years)

Birthplace Mount Pelier, Idaho (City and State or County)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ / ~~Stillborn~~ **at** 7 P **M. on the date above stated.**

(Signature) Will Brothers

(Physician or midwife)

Address Pocatello Ida

Filed 12/1 1930 J. H. Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

(REPRODUCTION PROHIBITED)

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Print. Registration District No. ..... Local Registrar's No. .....

(If any of the above information is not known, write "Unknown")

PLACE OF CHILD

(If stillborn, substitute the word "Stillborn" for place of birth)

Place of birth: City, village, or township ..... County ..... Legal residence of mother: City, village, or township ..... County .....

(Observe and do in over a month)

Number in order of birth ..... Legal residence of mother: City, village, or township ..... County .....

(Observe and do in over a month)

Other particulars with need to prevent Diphtheria Immunization*

Number of child of this mother, including present birth ..... (a) Born alive and now living .....

Born alive but now dead .....

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME
Residence (Last place of abode)	Residence (Last place of abode)
If not mother, give place of birth	If not mother, give place of birth
Color or race ..... Age at last birthday ..... (Years)	Color or race ..... Age at last birthday ..... (Years)
Birthplace (City and state or country)	Birthplace (City and state or country)
Occupation	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at ..... on the date above stated.

(Signature) .....

(Physician or Midwife)

Address .....

Filed ..... Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72631

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5939
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Harry Amundsen

(a) Residence. No. Pocatello, Idaho. St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 13, 1930.

7. AGE: Still-Born | Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Harry W. Amundsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pocatello, Idaho.
12. MAIDEN NAME OF MOTHER Margaret Evelyn Crane
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Montpelier, Idaho.

14. Informant Harry W. Amundsen
(Address) 1221 North Hayes Ave. Poca., Ida.

15. Filed 11/14/30, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 13, 1930, 19.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1930, to Nov 13, 1930, 19..
that I last saw him alive on Still born, 19....
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Still born

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Groves M. D.
11/14/30, 19.... (Address) Poca., Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. | Date of Burial: 11/14/30, 19

20. Undertaker: Arthur W. Hall | Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

451-107003849

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 86068

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. No. of City — Fish Hatchery

Pocatello General Registration District No. 28 State File No.

(If born in hospital or institution give name.) Prim. Registration District No. 2161 Local Registrar's No. 10.081

FULL NAME OF CHILD Sheldon Meader

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male	—		—	Yes	Nov. 7 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead 2 Stillborn 1

FATHER		MOTHER	
FULL NAME	Warren S. Meader	FULL MAIDEN NAME	Mae Hurelle
Residence (Usual place of abode)	Fish Hatchery No. of City	Residence (Usual place of abode)	Fish Hatchery No. of City
If non-resident, give place and State	—	If non-resident, give place and State	—
Color or race	White	Color or race	White
Age at last Birthday (Years)	46	Age at last Birthday (Years)	30
Birthplace (City and State or County)	Penn	Birthplace (City and State or County)	Inlet, Wisconsin
Occupation	Fish Culturist	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 12 M. on the date above stated.

(Signature) D C Ray

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Pocatello

Filed 12/1 1930 J. Manning

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72270

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5934

2. FULL NAME Infant Meader

(a) Residence. No. W. Cl City St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 7-1930

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS

10. NAME OF FATHER W. S. Meader
11. BIRTHPLACE OF FATHER (city or town) Penn
(State or Country)
12. MAIDEN NAME OF MOTHER May Hurelle
13. BIRTHPLACE OF MOTHER (city or town) Wis
(State or Country)

14. Informant W. S. Meader
(Address) Pocatello Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 7 30
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19, to Nov 7, 19 30
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Died in utero -
Detached placenta
with hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View — Date of Burial Nov 7 30
20. Undertaker Schumacher & Hendry Inc — Address Cary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

168-126-003-995

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

186094

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. — St.

No. 2 City

(If born in hospital or institution give name.)

Registration District No. 28 State File No.

Prim. Registration District No. 2161 Local Registrar's No. 10055

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? — and Number in order of birth — (To be answered only in event of plural births) | Legitimate? Yes | Date of birth Sept 26 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME S. Orval Johnson	FULL MAIDEN NAME Lulu Elizabeth Zieh
Residence (Usual place of abode) No. of City	Residence (Usual place of abode) No. 2 City
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 36 (Years)	Color or race White Age at last Birthday 27 (Years)
Birthplace David City, Nebr. (City and State or County)	Birthplace La Hogue, Lee (City and State or County)
Occupation Farming	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Respective~~ Stillborn at 5.9 M. on the date above stated.

(Signature) D. C. Ray

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Pocatello

Filed 12/1 1930 [illegible]

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF IDAHO

DEPARTMENT OF PUBLIC ASSISTANCE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

18609A

Registration District No. _____ State File No. _____

File. Registration District No. _____ Local Registrar's No. _____

PLACE OF CHILD

(If stillborn, substitute the word "Stillborn" for name of child)

Place	Number and street	Town	Date of birth
(Hospital or other)			(Day) (Month) (Year)

(Give maiden name if mother of legal birth)

Was Prophylactic eye drops used to prevent Ophthalmia Neonatorum?

Number of living children of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME
Residence (Usual place of abode)	Residence (Usual place of abode)
If non-resident, give place and State	If non-resident, give place and State
Color or race _____ Age at last birthday _____ (Years)	Color or race _____ Age at last birthday _____ (Years)
Birthplace (City and State or Country)	Birthplace (City and State or Country)
Occupation	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at _____ on the date above stated.

(Signature) _____

(Physician or Midwife)

Address _____

Filed _____ 19__

Address there was no attending physician or midwife, then the father, householder, etc., should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71969

PLACE OF DEATH
County of Bannock
City of Pocatello

CERTIFICATE OF DEATH
Registration District No. 28
Primary Registration District No. 2191
(No. Tyhee, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5408

206

2. FULL NAME Infant Johnson

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 26 30

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Ida

PARENTS

10. NAME OF FATHER S. O. Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Lulu Zieher
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant S. O. Johnson
(Address) Pocatello Ida

15. Filed Sept 26 1930 A. V. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to Sept 26, 1930
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Stillbirth
Monostrosity

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. C. Ray, M. D.
9-26, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Pocatello Ida
Date of Burial: Sept 26 1930

20. Undertaker: McHan Undt Co
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham

City of Blackfoot, Idaho

No. R.F.D.# I St.

515-227 006 313
(If born in hospital or institution give name.)

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 186142

Registration District No. 121 State File No.

Prim. Registration District No. 2184 Local Registrar's No. 363

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	November 27 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth Four (a) Born alive and now living Three

Born alive but now dead ~~One~~ none. Stillborn One

FATHER	MOTHER
FULL NAME Hans A. Nansen	FULL MAIDEN NAME Katie Talme
Residence (Usual place of abode) Blackfoot, Idaho	Residence (Usual place of abode) Blackfoot, Idaho
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 40 (Years)	Color or race White Age at last Birthday 36 (Years)
Birthplace Soda Springs, Idaho (City and State or Country)	Birthplace Soda Springs, Idaho (City and State or Country)
Occupation Farmer	Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was [redacted] at 7.30 P. M. on the date above stated.

(Signature) F. W. Mitchell
(Physician or midwife)

Address Blackfoot Idaho

Filed Dec. 2 1930 Mrs. Wales Patrick
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

REC'D DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72641

PLACE OF DEATH
County of Bingham
City of Bingham.

Registration District No. 121
Primary Registration District No. 2142
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 173

2. FULL NAME Unnamed Hansen

(a) Residence. No. 1 1/2 mi. N.W. from Blackfoot
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Still born			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work -----
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer ------

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Idaho

PARENTS

10. NAME OF FATHER Hans A. Hansen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Soda Springs, Idaho

12. MAIDEN NAME OF MOTHER Katie Talmie

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Soda Springs Idaho

14. Informant Hans A. Hansen.
(Address) Blackfoot Idaho

15. Filed Nov. 28, 1930 Mo Vales E. Cate
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1930 to November 27, 1930 that I last saw her alive on Nov. 27 1930 and that death occurred, on the date stated above, at 8/30 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still born, Premature at 7 month. Due to failure of circulation blood.
.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Influenza of Mother
.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J. W. Mitchell, M. D.
Nov. 28, 1930 (Address) Blackfoot Idaho

19. Place of Burial, Cremation, or Removal Ferns Ranch N.W. | Date of Burial Nov. 28 1930
20. Undertaker Hans A. Hansen | Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of RECEIVED NOV 25 1930

City of Burley

No. 346 S. Harrison St.

296 204 016 412

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH **186219**

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD Still birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	Oct 4th 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? 0

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 0

FATHER	MOTHER
FULL NAME Wallace Alma Brown	FULL MAIDEN NAME Phyllis Eliza Maley
Residence (Usual place of abode) Burley, Idaho.	Residence (Usual place of abode) Burley, Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 23 (Years)	Color or race White Age at last Birthday 20 (Years)
Birthplace Provo Utah. (City and State or County)	Birthplace Marion Idaho. (City and State or County)
Occupation Auto Mechanic	Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 12 40 P. M. on the date above stated.

(Signature) Nelson Fraser, M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Burley Idaho.

Filed 11-15-1930 F. H. Carter

Registrar.

[illegible] FIELD WORKER

[illegible]

196219

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registration District No. _____

[illegible] substitute the word "Mulatto" for negro or colored.

Child's name _____ Sex _____ Twin, triplet or quadruplet? _____ Number in order of birth _____ Legitimate? _____ Date of birth _____ 19 _____ (Year) (Day) (Month)

(Use separate line if more than one child born)

Other presumptive was used to establish identity? _____

Number of child of this mother including present birth _____

Date after last born dead _____

FATHER

Full name _____

Residence (Usual place of abode) _____

Birthplace (State or country) _____

Age at last birthday _____ (Years)

Occupation _____

MOTHER

Full maiden name _____

Residence (Usual place of abode) _____

Birthplace (State or country) _____

Age at last birthday _____ (Years)

Occupation _____

(a) Born alive and now living

Stillborn

DIRECTIONS OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive on the date above stated.

(Signature) _____

Address _____

Filed _____ 19 _____

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

431-106-027449

PLACE OF BIRTH

RECEIVED DEC 2 1930

County of Jerome

City of Jerome

No. ..... St.

St Valentine Hospital (If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 186304

Registration District No. 18 State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD - Stillborn -

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month) (Day) (Year)
male			yes	Nov 6 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% Argyrol

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead ..... Stillborn 2

FATHER	MOTHER
FULL NAME David McArthur	FULL MAIDEN NAME Emma L Murray
Residence (Usual place of abode) Jerome Idaho	Residence (Usual place of abode) Jerome Idaho
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 45 (Years)	Color or race White Age at last Birthday 38 (Years)
Birthplace Utah (City and State or County)	Birthplace Utah (City and State or County)
Occupation Farming	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ Stillborn } at 2 - 4 M. on the date above stated.

(Signature) Chas. F. Zeller M.D.

(Physician or midwife)

Address Jerome, Ida.

Filed 11/6 1930 Chas. F. Zeller

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72738

PLACE OF DEATH

County of Jerome
City of Jerome

CERTIFICATE OF DEATH

Registration District No. 18
Primary Registration District No. ..... Local Registrar's No. .....
(No. St Valentine Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby McArthur

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jerome Idaho.

PARENTS

10. NAME OF FATHER David McArthur
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Emma L Murray
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant David McArthur
(Address) Jerome Idaho.

15. Filed 11/6, 1930 Chas F. Zeller Jrome, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 6 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 6, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Prolapse Cord
Forceps delivery

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as **Day laborer Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal **meningitis"); Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Madison

City of Rexburg

No. ..... St.

595-213 033-299

(If born in hospital or institution give name.)

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

186390

Registration District No. 100 State File No. .....

Prim. Registration District No. 2178 Local Registrar's No. 318

FULL NAME OF CHILD Sarah Jane Niederer

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? ✓ and Number in order of birth ✓ (To be answered only in event of plural births) | Legitimate? Yes | Date of birth 11-13 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate 1%

Number of child of this mother, including present birth 8 (a) Born alive and now living 7

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Arthur Emil Niederer	FULL MAIDEN NAME Mary Lynn Bruce
Residence (Usual place of abode) Thornton, Ida.	Residence (Usual place of abode) Thornton Idaho
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 44 (Years)	Color or race White Age at last Birthday 37 (Years)
Birthplace South Cottonwood, Utah (City and State or County)	Birthplace Lyman Thornton Ida. (City and State or County)
Occupation Farming	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / ~~Stillborn~~ Still-Born} at 4 P. M. on the date above stated.

(Signature) W. Sutherland M.D.

(Physician or midwife)

Address Rexburg Idaho

Filed Dec 4 1930 J. R. Young Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1-14-31

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho DEC 29 1930

186390

Mrs. A.E. Niederer
Thonront

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Sarah Jane Niederer

PLACE OF BIRTH Rexburg DATE OF BIRTH Nov. 13, 1930 SEX OF CHILD Female

1. Number of children born to this mother, including present birth eight
2. Number born alive and now living seven
3. Born alive but now dead
4. Number of children stillborn one

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Arthur Ernest Niederer (Full name)	Mary Ann Briggs (Full maiden name)
Archer Idaho (Residence)	Archer Idaho (Residence)
Age at last birthday 45	Age at last birthday 37
South Cottonwood Utah (Birthplace)	Lyman Idaho (Birthplace)
Farmer (Occupation)	

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

REC'D DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72763

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2138
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 62

100

2. FULL NAME Baby Neidier

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stillborn
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rexburg Idaho

PARENTS

10. NAME OF FATHER: Arthur Neidier
11. BIRTHPLACE OF FATHER (city or town) (State or Country): South Cotton wood Utah
12. MAIDEN NAME OF MOTHER: Mary Ann Briggs
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Archer Idaho

14. Informant: Arthur Neidier
(Address): Archer Ida.

15. Filed Dec 4, 1930. J. R. Young, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth, 19..., to ..., 19...
that I last saw him alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still-birth, due to placenta-previa
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. Rutherford, M. D.
11-18, 1930 (Address) Rexburg, Idaho

19. Place of Burial, Cremation, or Removal: Archer Ida. | Date of Burial: Nov. 14 1930
20. Undertaker: Wm Gibbons | Address: Rexburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

291-116-040-867

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 186470

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Shoshone
City of Wallace
No. ..... St.
Providence
(If born in hospital or institution, give name.)

Registration District No. 70 State File No. .....
Prim. Registration District No. 1011 Local Registrar's No. 95

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin 1st ~~Triplet or other~~? and Number in order of birth 1st (To be answered only in event of plural births) | Legitimate? Yes | Date of birth March 16 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1st (a) Born alive and now living .....
Born alive but now dead ..... Stillborn 1st

FATHER	MOTHER
FULL NAME Arthur Joseph Kramis	FULL MAIDEN NAME Mary Alice Hopkins
Residence (Usual place of abode) Wallace	Residence (Usual place of abode) Wallace
If non-resident, give place and State	If non-resident, give place and State .....
Color or race W Age at last Birthday 35 (Years)	Color or race W Age at last Birthday 29 (Years)
Birthplace Montana (City and State or County)	Birthplace Indiana (City and State or County)
Occupation Forestry	Occupation Home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 2:17 P M. on the date above stated.

(Signature) James R Bean M.D
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address .....

Filed Oct 29 1930 F. L. Quigley
Registrar.

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 76319

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

704

PLACE OF DEATH

County of Shoshone

City of Wallace

2. FULL NAME Infant of A. J. Kramis

(a) Residence. No. 606 Pearl St. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho

PARENTS

10. NAME OF FATHER A. J. Kramis.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stamchester Mont

12. MAIDEN NAME OF MOTHER Allaire Hopkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lafayette Louisiana

14. Informant E. Kramis

(Address) 606 Pearl, Wallace Ida

15. Filed Mar 15, 1930. F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stillborn, 19, to, 19

~~that I last saw h~~ alive on 3/16/30, 19

and that death occurred, on the date stated above, at 1 10 a m.

The CAUSE OF DEATH* was as follows:

Stillborn (dead 6-8 wks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3/16/30 (Signed) James R Kraus, M. D.

19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Missoula, Mont. Date of Burial: March 17 1930

20. Undertaker: B. G. Morstell. Address: Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

436-223-028851

RECEIVED DEC 12 1930

PLACE OF BIRTH

County of Kootenai

City of Coeur d'Alene

No. [illegible] St.

[illegible]

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 186591

Registration District No. 30 State File No.

Prim. Registration District No. 1027 Local Registrar's No. 197

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	Nov. 23 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth One (a) Born alive and now living None

Born alive but now dead None Stillborn Yes, one.

FATHER	MOTHER
FULL NAME Elmer E. McFee	FULL MAIDEN NAME Gladys M. Headley
Residence (Usual place of abode) 960 6th St.	Residence (Usual place of abode) 960 6th St.
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 35 (Years)	Color or race White Age at last Birthday 24 (Years)
Birthplace Darby Mont. (City and State or County)	Birthplace Baker Ore. (City and State or County)
Occupation Carpenter	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born Alive~~ / Stillborn} **at** 2 30 P. M. **on the date above stated.**

(Signature) John O. Wood

(Physician or ~~midwife~~)

Address Coeur d'Alene Idaho

Filed Nov 27 1930 H. J. Sturgess Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

72872

S

[illegible] STATISTICS

[illegible] OF BIRTH 16[illegible]

Registration District No. [illegible]

Prim. Registration District No. [illegible] Sub-District No. [illegible]

(If children, enumerate the same chronologically for each of mother.)

Name of child	Sex	Number and order of birth (Legitimate or illegitimate)	Length. Month	Place of birth (Street)	(Town)	(County)

Other particulars are used to prevent duplicate registration.

Number of child of this mother including present child [illegible]

Born alive but now dead [illegible]

FATHER

Name [illegible]

Surname (Family name) [illegible]

Birthplace (Town or parish) [illegible]

Date of birth [illegible]

Occupation [illegible]

MOTHER

Maiden surname [illegible]

Surname (Family name) [illegible]

Residence (Usual place of abode) [illegible]

If non-resident give place of usual residence [illegible]

Date of marriage [illegible]

Birthplace (Town or parish) [illegible]

Occupation [illegible]

Age at last Birthday [illegible]

Dwelling (Street and house or number) [illegible]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child who was delivered alive on the date above stated.

(Signature) [illegible]

(Physician or midwife)

Address [illegible]

Date [illegible] 19[illegible]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that, neither breathing nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72872

Local Registrar's No. 161

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

(No. Page Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gladys McFee

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): Nov 23, 1920

7. AGE: Years — Months — Days — If LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER: Elmer McFee

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Loreen Headley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oregon.

14. Informant: Elmer McFee

(Address): Coeur d'Alene Idaho

15. Filed Nov 29, 1930 H. J. Sturgeo Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Monstrosity.
Anencephalia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) Harold T. Anderson, M. D.

11-24, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery — Date of Burial: Nov 24 1930

20. Undertaker: None — Address: —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 186602

PLACE OF BIRTH

County of Lemhi

City of Salmon

No. ..... St.

Salmon General Hospital

(If born in hospital or institution give name.)

Registration District No. 11 State File No. .....

Prim. Registration District No. 2116 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
—				yes	Oct 27 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth One (a) Born alive and now living None

Born alive but now dead None Stillborn .....

FATHER	MOTHER
FULL NAME Jorvan Beyam	FULL MAIDEN NAME Margaret Steele
Residence (Usual place of abode) Lidian Creek	Residence (Usual place of abode) Indian Creek
If non-resident, give place and State	If non-resident, give place and State .....
Color or race Wh Age at last Birthday 31 (Years)	Color or race Wh Age at last Birthday 22 (Years)
Birthplace Mont (City and State or County)	Birthplace Wyoming (City and State or County)
Occupation Rancher	Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 9 P. M. on the date above stated.

(Signature) T. S. Wright M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Salmon

Filed 12/10 1930 Chas Bellamy Registrar

[illegible]

[illegible]

[illegible]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH DEC 13 1930

County of Twin Falls

City of Twin Falls

No. ..... St.

T.F. Co. Hosp.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 186605

Registration District No. 37 State File No.

Prim. Registration District No. 2085 Local Registrar's No. 502

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				Yes	Nov 26 1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 16 (a) Born alive and now living 12

Born alive but now dead 2 Stillborn 3

FATHER		MOTHER	
FULL NAME	Frank Weighall	FULL MAIDEN NAME	Agatha Wells
Residence (Usual place of abode)	Hansen	Residence (Usual place of abode)	Hansen
If nonresident, give place and State	R2 Idaho	If nonresident, give place and State	R2 Idaho
Color or race	W	Color or race	W
Age at last Birthday (Years)	49	Age at last Birthday (Years)	46
Birthplace (City and State or Country)	Oakley Idaho	Birthplace (City and State or Country)	Wash
Occupation	Laborer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 6 20 A. M. on the date above stated.

(Signature) C. D. Weaver

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address [redacted]

Filed [redacted]

MAY 1 0 1979

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Ada

City of Boise

No. 1617 N. 24 St.

The Salvation Army

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

186675

CERTIFICATE OF BIRTH FILED JAN 10 1931

S

Registration District No. 3 State File No.

Prim. Registration District No. 1004 Local Registrar's No. 603

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin ~~Triplet or other?~~ and Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month) (Day) (Year)
male	2	yes	Dec. 17 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? ~

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME John Joseph Lipscomb	FULL MAIDEN NAME Isobel B Bremner
Residence (Usual place of abode) 1115 O'Farrel	Residence (Usual place of abode) 1115 O'Farrel
If non-resident, give place and State Boise, Ada	If non-resident, give place and State Boise, Idaho
Color or race White Age at last Birthday 29 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Tennessee (City and State or County)	Birthplace Keith, Scotland (City and State or County)
Occupation Cook	Occupation Stenographer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 10:05 A. M. on the date above stated.

(Signature) Gustomey MD

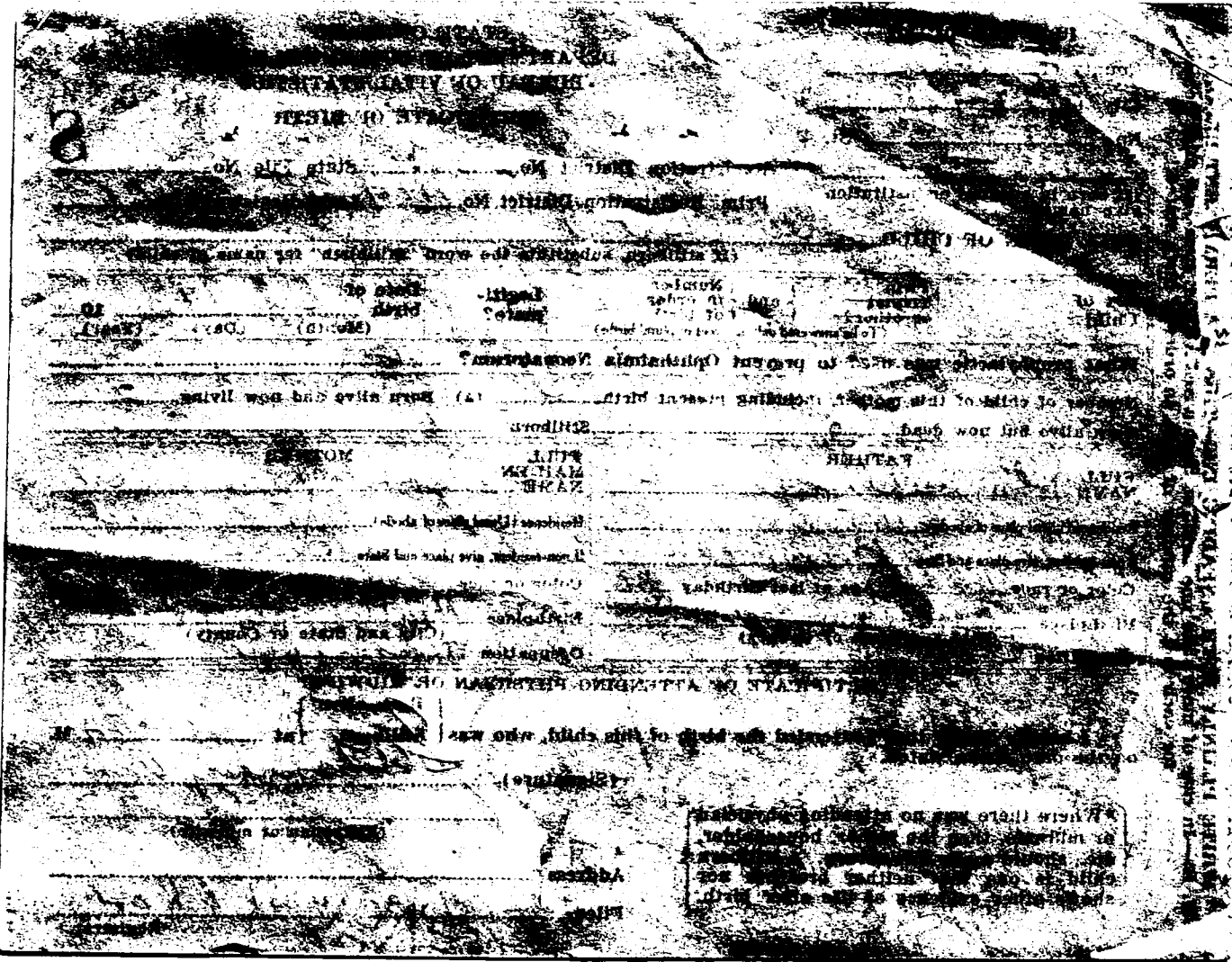
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 12-29 1930 W. H. Rhodes

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72967

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 324
(No. Salvation Army Rescue Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Lipscomb.

(a) Residence. No. 206 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) December 17th 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS
10. NAME OF FATHER John J. Lipscomb.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Isabel Bremner.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland.

14. Informant John J. Lipscomb.
(Address) Boise, Idaho.

15. Filed 12-19, 1930 W. H. Rodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 17th 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 19 30, to Dec 17, 19 30
that I last saw h.. alive on not alive, 19..
and that death occurred, on the date stated above, at 6 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still born (twin)

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Twisted umbilical cords
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Attorney, M. D.
12/19130, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: County Cemetery. Date of Burial: 12/19/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Bear Lake
City of Raymond
No. ..... St.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

186793

RECEIVED JAN 8 1931

S

Registration District No. 54 State File No. 186793
Prim. Registration District No. 2136 Local Registrar's No. .....

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? yes | Date of birth 8 (Month) 12 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 2 (a) Born alive and now living 0
Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME John Elmer Reeves	FULL MAIDEN NAME Mabel Fenaches
Residence (Usual place of abode) Raymond	Residence (Usual place of abode) Raymond
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 35 (Years)	Color or race white Age at last Birthday 20 (Years)
Birthplace Wyo. (City and State or Country)	Birthplace Ida (City and State or Country)
Occupation Rancher	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 1:30 p. M. on the date above stated.

(Signature) J. P. Gardner M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Montpelier Ida

Filed 12/31/1930 H H Kerr
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73005

PLACE OF DEATH
County of Bear Lake
City of Raymond

Registration District No. 32
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.) 206

Local Registrar's No.

REGISTERED JAN 8 1931

2. FULL NAME Stillborn infant Reeves

(a) Residence. No. Raymond Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 8-12-30

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.
Stillborn

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raymond

PARENTS
10 NAME OF FATHER John Elmer Reeves
11 BIRTHPLACE OF FATHER (city or town) (State or country) Alma Wyo.
12 MAIDEN NAME OF MOTHER Mabel Hughes
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raymond Ida

14 Informant L. P. Galyline
(Address) Montpelier

15 Filed 12/31/1930 J. N. Kerr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 (Month) 12 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/12, 1930, to 8/12, 1930, that I last saw he alive on , 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Unknown
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. P. Galyline M. D.
8-12-1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Raymond
Date of Burial: 8/12/1930

20. Undertaker: Bishop Sons
Address: Raymond

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report 'Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 5 1931

PLACE OF BIRTH

County of Bingham

City of Basalt

No. ..... St. -

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 186830

Registration District No. 121 State File No. -

Prim. Registration District No. 2194 Local Registrar's No. 399

FULL NAME OF CHILD Stillborth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child male | Twin / Triplet / or other? — (To be answered only in event of plural births) | and Number in order of birth 4th | Legitimate? yes | Date of birth Dec (Month) 22 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 4 (a) Born alive and now living 5

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Ellis Armstrong	FULL MAIDEN NAME Vinona Maude Kindall
Residence (Usual place of abode) Basalt	Residence (Usual place of abode) Basalt
If nonresident, give place and State	If nonresident, give place and State
Color or race white Age at last Birthday 36 (Years)	Color or race white Age at last Birthday 35 (Years)
Birthplace Utah (City and State or Country)	Birthplace Utah (City and State or Country)
Occupation Farmer	Occupation Housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 10:45 a. M. on the date above stated.

(Signature) H. E. Gurnett. M.D.

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Shelley, Idaho.

Filed Jan 1 1931 Mrs. Walter E. Patrie
Registrar.

STATE OF [illegible]

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Print. Registration District No. _____ Local Registrar's No. _____

PLACE OF BIRTH

County of _____

City of _____

No. _____ St. _____

(If born in hospital or institution give name)

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillborn" for name or [illegible])

Sex of child	Twins; or triplets, or other	Number in order of birth (To be answered only in event of plurality)	Legitimate?	Date of birth
				19

(Month) (Day)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

	FATHER	MOTHER
FULL NAME		
FULL MAIDEN NAME		
Residence (Usual place of abode)		
If nonresident, give place and State		
Color or race	Age at last Birthday (Years)	Age at last Birthday (Years)
Birthplace (City and State or Country)		
Occupation		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / Stillborn at _____ on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____ 19 _____ Registrar _____

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE PLANNING BOARD
PLACE OF BIRTH
N. B.—In case of twins or triplets, a separate form must be made for each child.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[illegible] JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73035

PLACE OF DEATH
County of Bingham
City of Basalt

Registration District No. 121
Primary Registration District No. 2192

Local Registrar's No. 187

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth Baby Armstrong 206

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. none mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 0 Months 0 Days 0 If LESS than 1 day, 0 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9. BIRTHPLACE (city or town) (State or country): Basalt, Ida

PARENTS

10. NAME OF FATHER: Ellis Armstrong
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Alvona Maude Kindall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Elas Armstrong
(Address) Basalt Idaho

15. Filed Dec. 23, 1930 Miss Martin E. Farrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1930, to Dec 22, 1930
that I last saw h. ~~im alive on~~ dead, 19..
and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:
Stillbirth

0 (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) none
..(duration) ..yrs. ..mos. ..ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis Usual Physical Signs
(Signed) H. E. Guyett, M. D.
12/23, 1930 (Address) Shelley, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Firth Cemetery — Date of Burial: Dec 23 1930.

20. Undertaker: Elas Armstrong — Address: Basalt Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 2 1931

County of Bonneville

City of Idaho Falls Idaho

No. ..... St.

P.D.L. Hospital

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 186888

Registration District No. 73 State File No. .....

Prim. Registration District No. 21-70 Local Registrar's No. 546

FULL NAME OF CHILD Stillborn Prestwich

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin ~~Triplet or other~~? and Number in order of birth 2 (To be answered only in event of plural births) | Legitimate? Yes | Date of birth 11 – 26 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 10 (a) Born alive and now living 6

Born alive but now dead 1 Stillborn 3

FATHER	MOTHER
FULL NAME George M. Prestwich	FULL MAIDEN NAME Ruth Munson
Residence (Usual place of abode) South Idaho Falls	Residence (Usual place of abode) Same —
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 50 (Years)	Color or race White Age at last Birthday 39 (Years)
Birthplace Marion, Utah (City and State or County)	Birthplace Ogden Utah (City and State or County)
Occupation Farmer	Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~born alive~~ Stillborn at 10 47 P. M. on the date above stated.

(Signature) John O. Miller M.D.

(Physician or ~~Midwife~~)

Address Idaho Falls, Idaho

Filed 12/13 1930 Certificate

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73082

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH
Registration District No. 73
Primary Registration District No. 21 V 0 Local Registrar's No. 231
(No. 206 St.)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Baby Prestwich.
(a) Residence. No. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 26, 1930

7. AGE Years | Months | Days | If LESS than 1 day, hrs. or Stillborn min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Bonneville Co. Idaho

PARENTS
10. NAME OF FATHER George M. Prestwich.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Marsing, Utah
12. MAIDEN NAME OF MOTHER Ruth Munsee
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ogden, Utah

14. Informant (Address) N. C. Miller M.D. Idaho Falls

15. Filed Jan 2, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 26 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still-born - Monstrosity - Causes unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Mellor M. D.
Dec 1, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida — Date of Burial 1/26 1930

20. Undertaker: None — Address

A stillbirth must be registered **both as a birth and a death.** The date of death should be the date of delivery and the death certificate should further state, if **known**, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JAN 3 1931

PLACE OF BIRTH

County of Caribou

City of Soda Springs

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 187155

Registration District No. 82 State File No.

Prim. Registration District No. 259 Local Registrar's No. 39

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin Triplet or other? — and Number in order of birth — (To be answered only in event of plural births) | Legitimate? yes | Date of birth Nov. 22 1930 (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 9 (a) Born alive and now living 7

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Kenneth G. Bells	FULL MAIDEN NAME Zina Horsley
Residence (Usual place of abode) Soda Springs	Residence (Usual place of abode) Soda Springs
If non-resident, give place and State —	If non-resident, give place and State —
Color or race White Age at last Birthday 38 (Years)	Color or race White Age at last Birthday 40 (Years)
Birthplace Alexander Ida (City and State or County)	Birthplace Soda Springs, Ida (City and State or County)
Occupation Farmer & Bishop	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 7.40 a. M. on the date above stated.

(Signature) Russell Tigert

(Physician ~~or midwife~~)

Address Soda Springs, Ida

Filed 1/1/30 1930 Dr. Russell Tigert Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

for each and the number of each, in order of birth stated.

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1310

PLACE OF DEATH
County of Bonneville
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159

Local Registrar's No. 31

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Bells

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): 11-22-30

7. AGE: Years — Months — Days: Stillborn — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Still born
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Soda Springs Idaho

PARENTS

10. NAME OF FATHER: Kenneth Bells
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Soda Springs Idaho
12. MAIDEN NAME OF MOTHER: Zina Hensley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Soda Springs Idaho

14. Informant: X Kenneth G Bells
(Address): Soda Springs Ida

15. Filed 11-22, 1930 Dr Russell Tigert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to at birth 19..
that I last saw h... alive on ....., 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: stillborn - cause probably trauma to mother who accidentally fell down basement steps (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? None
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) Russell Tigert, M. D.
Nov 22, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Soda Springs Ida — Date of Burial: 11-22 1930

20. Undertaker: E L Witherman — Address: Soda Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 7 1931

County of Ib

City of

No. St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 187162

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Boy | Twin Triplet or other? Twin 1 | and | Number in order of birth | Legitimate? Yes | Date of birth Nov 3 (Month) (Day) 1930 (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate 2%

Number of child of this mother, including present birth one (a) Born alive and now living one

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME Joseph LeRoy Squires	FULL MAIDEN NAME Virginia Anderson
Residence (Usual place of abode) Mustangh	Residence (Usual place of abode) Mustangh
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 18 (Years)
Birthplace Utah (City and State or County)	Birthplace Idaho (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 6:30 A.M. on the date above stated.

(Signature) Hugh E. Dean

M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Burley, Idaho.

Filed 1-2- 1931 [illegible]

Registrar.

NURSE'S CERTIFICATE OF LIVE BIRTH—THIS IS A PERMANENT RECORD

X. B.—In completing this form, be sure to write in ink, a soft pencil, or typewriter. Do not use ink or pencil. In order of birth, attendants must be made for each and the number of each child in multiple births.

PLACE OF BIRTH

County of _____

City _____

No. _____ St. _____

Is a hospital or institution _____

FULL NAME OF CHILD _____ (If no name, substitute the word "Stillborn" for name of child)

Sex of Child	Twins or triplets? (Or number of child)	Legitimate?	Date of birth (Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including previous births, living and dead _____

Born alive but now dead _____

CHILD	FATHER	MOTHER
NAME	FULL NAME	
	MAIDEN NAME	
	AGE	

Legitimate? _____ Nationality _____

Legitimate? _____ Nationality _____

Color or race _____ Age at last birthday _____

Birthplace (City and State or Country) _____

Occupation _____ Occupation _____

(CERTIFICATE OF PHYSICIAN OR MIDWIFE OR ATTENDANT)

I hereby certify that I attended the birth of this child, who was born alive at _____ on the date above stated.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____ 19 _____

Registrar

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A affidavit signed by one that actually breathes not shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Filing Registration District No. _____ Local Registrar's No. _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73199

PLACE OF DEATH

County of Cassia

City of Burley

CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Baby Squires

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 3 1930

7. AGE Years | Months | Days STILL BORN | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Roy Squires

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Virginia Anderson

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Idaho.

14. Informant Mrs. Virginia Squires
(Address) Murtaugh Ida

15. Filed Nov 11 —, 1930 F H Cutler
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 3 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 -, 1930, to Nov 3, 1930
that I last saw alive on Nov 3, 1930
and that death occurred, on the date stated above, at 7.30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intra Uterine Asphyxia
.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [illegible], M. D.
Nov 3, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal Burley Ida — Date of Burial Nov. 5-30

20. Undertaker D.E.Johnson — Address Burley Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 7 1931

County of 16

City of

No. St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH S 187163

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Twin

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Boy	2		yes	Nov 3 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 2%

Number of child of this mother, including present birth one (a) Born alive and now living one

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME Joseph LeRoy Squires	FULL MAIDEN NAME Virginia Anderson
Residence (Usual place of abode) Montpelier	Residence (Usual place of abode) Montpelier
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 18 (Years)
Birthplace Utah (City and State or County)	Birthplace Idaho. (City and State or County)
Occupation Farmer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 6:40 A.M. on the date above stated.

(Signature) Hugh E. Dean M. D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Burley, Ida.

Filed 1-2-1931 J. H. Cutler

Registrar.

NOTICE REGARDING WRITTEN DECLARATIONS ON—THIS IS A PERMANENT RECORD

X. B.—If more than one child or death is given, attach a separate certificate for each. In case of twins, and the number of each, in order of birth.

PLACE OF BIRTH

County of .....

City or .....

No. ..... St. .....

(If born in hospital or institution give name.)

FULL NAME OF CHILD

(If not born, substitute the word "Stillborn" for name of child)

Sex of Child	Twin, Triplet or other?	Number in order of birth.	Length. Inches	Date of birth (Month)	(Day)	(Year)

(Fill numerical in order of birth)

When prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth ..... (a) Born alive and now living ..... (b) Born alive but now dead ..... (c) Stillborn .....

	FATHER	MOTHER
Full name		
Residence (Usual place of abode)		
Business (Kind of work done)		
Color or race		
Age at last birthday (Years)		
Birthplace (Country, state or province)		
Citizenship		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / Stillborn on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19..

Where there was no attending physician or midwife (as the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Local Registrar's No. ..... Filed. Registration District No. .....

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 7 1931

PLACE OF BIRTH

County of Cassia

City of Burley

No. ..... St. .....

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

187168

Registration District No. 19 State File No. .....

Prim. Registration District No. 2015 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				yes	Nov 20 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo Silval 1%

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead ..... Stillborn 1

FATHER		MOTHER	
FULL NAME	Archie McLean	FULL MAIDEN NAME	Margaret Lee
Residence (Usual place of abode)	Burley	Residence (Usual place of abode)	Burley
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White	Color or race	White
Age at last Birthday (Years)	50	Age at last Birthday (Years)	38
Birthplace (City and State or County)	Ontario Canada	Birthplace (City and State or County)	Grinnell Iowa
Occupation	Laborer Mines	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 9:50 P. M. on the date above stated.

(Signature) E. V. Elmore M.D.

(Physician or midwife)

Address Rupert

Filed Dec 9 1930

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible] RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 73201

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No.

Primary Registration District No.

(No. St.)

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH Nov (Month) 20 (Day) 1930 (Year)

7. AGE ___ Yrs. ___ Mos. ___ ds.

IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Burley Idaho

10. NAME OF Father Archie McLean

11. BIRTHPLACE OF FATHER (State or Country) Ontario Canada

12. MAIDEN NAME OF MOTHER Margaret Lee

13. BIRTHPLACE OF MOTHER (State or Country) Grinnell, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Archie McLean
(Address) Burley

15. Filed 1-2-1931 F H Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH 206

16. DATE OF DEATH Nov (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19__, to ____ 19__,
that I last saw h... alive on ____ 19__,
and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:
Stillborn, full term
Hydrocephalus +
Spina Bifida
(Duration) ___ yrs. ___ mos. ___ ds.
Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) E M Elmore M. D.
12-10 1930 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ____ 19__

20. UNDERTAKER | **ADDRESS**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of .....

City of .....

No. 493 213.016 319 St.

(If born in hospital or institution give name.)

RECEIVED DEC 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

187180

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child: Girl | Twin / Triplet / or other? and Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth: Nov (Month) 13 (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth: three (a) Born alive and now living: two

Born alive but now dead: 0 Stillborn: one

FATHER	MOTHER
FULL NAME: George T. Mitchel	FULL MAIDEN NAME: Myrle Carson
Residence (Usual place of abode): Burley	Residence (Usual place of abode): Burley
If non-resident, give place and State:	If non-resident, give place and State:
Color or race: White Age at last Birthday: 32 (Years)	Color or race: White Age at last Birthday: 31 (Years)
Birthplace: Idaho. (City and State or County)	Birthplace: Idaho (City and State or County)
Occupation: Farming	Occupation: Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 11:55 P.M. on the date above stated.

(Signature) Hugh E. Dean

M. D.

(Physician or midwife)

Address: Burley

Filed 12-12-1930 J. H. Cutler

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF [illegible]

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

(If born in hospital or institution give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillborn" for name of child.)

Sex of child	Twin, triplet or others?	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
		(If twin or triplet, state whether first, second, third)		

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth ..... (a) Born alive and now living ..... (b) Born alive but now dead ..... (c) Stillborn .....

	FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME	
Residence (Usual place of abode)	Residence (Usual place of abode)	
If non-resident, give place and state	If non-resident, give place and state	
Color or race	Age at last birthday (Years)	Color or race / Age at last birthday (Years)
Birthplace	Birthplace	
Occupation	Occupation	

(City and state or country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive or stillborn at ..... on the date above stated.

(Signature)

(Physician or Midwife)

Address .....

Filed ..... 19 .....

Registrar

When there was no attending physician or midwife, then the father, householder, or owner should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

187180 +

REC'D DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73195

PLACE OF DEATH

County of Cassia

City of Burley

CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2b

2. FULL NAME Baby Mitchell

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 14 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Still Born			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Burley, Ida.

PARENTS

10. NAME OF FATHER Geo. T. Mitchell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelley, Ida.

12. MAIDEN NAME OF MOTHER Myrle Carson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oakley, Ida.

14. Informant Geo. T Mitchell
(Address) Burley Ida

15. Filed Dec 10, 1930 F. H. Cutler
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1930, to Nov. 14, 1930 that I last saw her alive on Nov 14, 1930 and that death occurred, on the date stated above, at 11:00 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Inertia Uterine Complete

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [illegible], M. D.
Nov 15, 1930 (Address) Burley Id

19. Place of Burial, Cremation, or Removal Burley Ida — Date of Burial Nov. 14 1930

20. Undertaker D. E. Johnson — Address Burley Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

168-113-018-493

JAN 7 1931

PLACE OF BIRTH

County of Clearwater

City of Ahsahka

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 187215

Registration District No. 90 State File No. .....

Prim. Registration District No. 2187 Local Registrar's No. 107

FULL NAME OF CHILD Arthur Joy

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month)	(Day)	(Year)
M.				Yes	12	13	1930

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME Scott Joy	FULL MAIDEN NAME Edna Miller
Residence (Usual place of abode) Ahsahka	Residence (Usual place of abode) Ahsahka
If nonresident, give place and State	If nonresident, give place and State .....
Color or race Indian Age at last Birthday 41 (Years)	Color or race Indian Age at last Birthday 26 (Years)
Birthplace Ida Mont. (City and State or Country)	Birthplace Ida (City and State or Country)
Occupation Labor	Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 11:a M. on the date above stated.

(Signature) Mrs Adams Mother of Boy

(Physician or midwife)

Address Ahsahka Ida

Filed 12/13 19..... V. A. Shaw

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73212

PLACE OF DEATH
County of Clearwater
City of Ahsahka

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 89

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Baby not named

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 13 - 1930

7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Now Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ahsahka Ida

PARENTS

10. NAME OF FATHER: Scott Joy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ida
12. MAIDEN NAME OF MOTHER: Edna Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ida

14. Informant: Mrs Adams
(Address): Ahsahka

15. Filed 12/13, 19.... V. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:

Burned Head
Had no Lungs
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) V. A. Shaw Coroner, ~~M. D.~~
12/13, 19.... (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ahsahka Ida	Dec 14 19

20. Undertaker	Address
V. A. Shaw	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

187215

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such,** if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

LEWIS WILLIAMS
SPECIAL AGENT

187215 Boise, Idaho JAN 28 1931

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due time.

FULL NAME OF CHILD Arthur Joy

PLACE OF BIRTH Ahsahka Idaho DATE OF BIRTH Dec 13 1931 SEX OF CHILD boy

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living one girl Hattie Joy
3. Born alive but now dead 4 boys that are dead
4. Number of children still born

(Please write plainly)

Information with reference to FATHER	Information with reference to MOTHER
Scott Joy (Full name)	Mrs Edna Miller Joy (Full MAIDEN name)
Ahsahka Idaho (Residence)	Ahsahka Idaho (Residence)
Age at last birthday 41	Age at last birthday 26
Nebraska (Birthplace)	Ahsahka Idaho (Birthplace)
Labor on Rail Road Section (Occupation)	not able to work Blind for (Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,
Lewis Williams
Lewis Williams
Special Agent, Bureau of the Census.

632-27-027-399

RECEIVED JAN 7 1931

PLACE OF BIRTH

COUNTY OF Franklin

PRECINCT OF

TOWN OR VILLAGE OF

CITY OF Preston

STATE BOARD OF HEALTH FILE NO.

CERTIFICATE OF BIRTH

S

STATE OF ~~UTAH~~ IDAHO

187230

STREET AND NO. ~~4~~ 27

(If in Hospital or other Institution, give its Name instead of Street and Number)

FULL NAME OF CHILD

(If child is not yet named, make supplemental report as directed)

SEX OF CHILD F. | TWIN, TRIPLET, OR OTHER? | NUMBER IN ORDER OF BIRTH (To be answered in event of plural births) | PREMATURE — | FULL TERM — | LEGITIMATE? Yes. | DATE OF BIRTH Dec 12, 1930 (MONTH) (DAY) (YEAR)

FATHER	MOTHER
FULL NAME Perley Orme Andrew Olsen	FULL MAIDEN NAME Versa M Bright
RESIDENCE (USUAL PLACE OF ABODE) Preston Idaho	RESIDENCE (USUAL PLACE OF ABODE) Preston, Idaho
COLOR OR RACE W — AGE AT LAST BIRTHDAY 31 (YEARS)	COLOR OR RACE W — AGE AT LAST BIRTHDAY 30 (YEARS)
BIRTHPLACE (CITY OR PLACE) (STATE OR COUNTRY) Norway	BIRTHPLACE (CITY OR PLACE) Richmond (STATE OR COUNTRY) Utah
OCCUPATION: TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC. Farmer.	OCCUPATION: TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS HOUSEKEEPER, TYPIST, NURSE, CLERK, ETC. H.W.
INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAWMILL, BANK, ETC.	INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS OWN HOME, LAWYER'S OFFICE, SILK MILL, ETC.

NUMBER OF CHILDREN OF THIS MOTHER (AT TIME OF THIS BIRTH AND INCLUDING THIS CHILD) (a) BORN ALIVE AND NOW LIVING 1 (b) BORN ALIVE BUT NOW DEAD — (c) STILLBORN 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE* 328

I HEREBY CERTIFY THAT I ATTENDED THE BIRTH OF THIS CHILD WHO WAS Stillborn (Born alive or stillborn) AT 3½ M. ON THE DATE ABOVE STATED.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(SIGNATURE) J. Hayward (PHYSICIAN OR MIDWIFE)

DATE 12-12-30, 1930

ADDRESS OF PHYSICIAN OR MIDWIFE Logan Utah

GIVEN NAME ADDED FROM SUPPLEMENTAL REPORT

, 19

REGISTRAR

FILED 1/3/31, 19

A. R. Cullin REGISTRAR

REGISTERED NO. 292.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated. SEE INSTRUCTIONS ON OTHER SIDE.

Information for Physicians, Midwives, Parents and Others Required to Report Births

REPORTS

Section 5051, Compiled Laws of Utah, 1917. That it shall be the duty of the Attending Physician or Midwife to file a certificate of birth, giving all the particulars required by this Act, with the local registrar of the district in which the birth occurred, within ten days after the date of birth. And if there be no attending physician or midwife, then it shall be the duty of the Father of the child, Householder or Owner of the premises, Manager or Superintendent of Institution in which the birth occurred, to file said certificate of birth with the local registrar within three days after the birth.

EVERY ITEM OF INFORMATION IS IMPORTANT AND MUST BE SUPPLIED

The Full Name of the child is necessary for identification. If the child is not named when the report is made, get a blank from local registrar and make return of name as soon as child is named.

DO NOT OMIT ANY FACTS RELATING TO THE PARENTS OF THE CHILD

Section 5055, Compiled Laws of Utah, 1917, provides that: * * * "All Physicians, Midwives, Informants * * * connected with any case, and all other persons having knowledge of the facts, are hereby required to furnish such information as they may possess regarding any birth or death, upon demand of the State Registrar, in person, or by mail, or through the local registrar." * * * The State Registrar will not accept as complete a certificate with this data omitted without satisfactory explanation for failure to report same.

When no physician or midwife attended a birth the persons required to make the report in the order specified in Section 5051 shall strike out the words "I hereby certify that I attended the birth of this child," and write in lieu thereof the words "No Physician or Midwife," filling out the remainder of the certificate as the law requires and sign as father, householder, etc., as the case may be, with his address.

INSTRUCTIONS TO LOCAL REGISTRARS

Read carefully the law relating to the registration of births and do not allow your supply of blanks to become exhausted before requesting more.

Carefully examine each certificate as soon as it is filed, and if the facts required by law are not all supplied, return same for complete report. Enter the date of filing in your office immediately; give the certificate its proper registered number and make a copy of the original certificate for your local record. If the name of the child is not reported give the person who made the return a blank for supplemental report of name and direct that it be sent to you as soon as the child is named.

Send all original certificates to the State Board of Health on or before the fifth of the month. If the supplemental report of name of child has not yet been filed, send the certificate and forward the latter report as soon as received after entering name or other fact on your copy. If the child died before being named, the report should be made with the statement "died unnamed."

PENALTY

Section 5059, Compiled Laws of Utah, 1917. And any physician or midwife in attendance upon a case of confinement, or any other person charged with responsibility for reporting births, in the order named in Section 5051 of this Act, who shall neglect or refuse to file a proper certificate of birth with a local registrar, within the time required by this Act, shall be deemed guilty of a misdemeanor. * * * And any registrar, or deputy registrar, who shall neglect or fail to enforce the provisions of this Act in his district, or shall neglect or refuse to perform any of the duties imposed upon him by this Act or by the instructions and direction of the State Registrar, shall be deemed guilty of a misdemeanor. * * * Any person convicted of a misdemeanor under the provisions of this Act, shall be fined in any sum not less than ten dollars nor more than two hundred dollars.

Blank birth certificates may be obtained from Local Board of Health, Local Registrars or the State Board of Health.

Statement of Occupation.—Make some entry in this section for each parent. For a woman whose only occupation is that of home housework, write *housework* in answer to first Question and *own home* in answer to second Question. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *housekeeper—private family, cook—hotel,* etc. For a person who has no occupation whatever write *none.*

To be complete, an occupation return must state:

The trade, profession, or particular kind of work done.

The industry or business in which the work is done.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver,* etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill,* etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer,* etc. Avoid the term "laborer" when a more precise statement of occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter, painter, machinist,* etc. Distinguish carefully between *retail merchants* and *wholesale merchants.* A person who sells goods should be called a *salesman* and not a *clerk.*

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 187259

County of Fremont

City of St. Anthony

No. ..... St. Registration District No. 99 State File No. .....

Hospital ..... Primary Registration District No. 2177 Local Registrar's No. 1119

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) Nov. (Day) 13, (Year) 1930

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth 0 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	Wilford Dell Wardle	FULL MAIDEN NAME	Ula Pugmire
RESIDENCE	Parker	RESIDENCE	Parker
COLOR	white	COLOR	white
AGE AT LAST BIRTHDAY	29 (Years)	AGE AT LAST BIRTHDAY	19 (Years)
BIRTHPLACE		BIRTHPLACE	Salem
OCCUPATION	Laborer	OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born Alive~~ / Stillborn} at 10. a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. Allison

M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address .....

..... , 192.....

..... Registrar.

Filed Dec 31 1930 Lon Hansen Registrar.

MOD

To file
Cert. Charged

18725-9

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

LEWIS WILLIAMS
SPECIAL AGENT

Boise, Idaho. JAN 28 1931

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due time.

FULL NAME OF CHILD unchristioned

PLACE OF BIRTH Hesman Ida DATE OF BIRTH 17th of Nov. SEX OF CHILD Boy

1. Number of children born to this mother, including present birth 1 Child.
2. Number born alive and now living None
3. Born alive but now dead None
4. Number of children stillborn 1 born dead.

(Please write plainly)

Mr Wilford D Hardle

Information with reference to FATHER	Information with reference to MOTHER
Wilford Dell Hardle (Full name)	Miss Ula Velora Pugm (Full MAIDEN name)
Hesman Idaho (Residence)	Hesman Ida (Residence)
Age at last birthday 29 yrs	Age at last birthday 19 yrs
Parker Ida (Birthplace)	Salem Ida (Birthplace)
Labor (Occupation)	(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,
Lewis Williams
Lewis Williams
Special Agent, Bureau of the Census.

386-126-027-759

PLACE OF BIRTH

County of Jerome

City of Jerome

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

RECEIVED JAN 9

S 187321

Registration District No. 18 State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD .....

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Male				Yes	Dec 26 (Month) (Day) 1930 (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Adam Edgar Thompson	FULL MAIDEN NAME Blanch Perkins
Residence (Usual place of abode) Jerome	Residence (Usual place of abode) Jerome Idaho
If non-resident, give place and state	If non-resident, give place and state
Color or race White Age at last Birthday 40 (Years)	Color or race White Age at last Birthday 37 (Years)
Birthplace Utah (City and State or County)	Birthplace Utah (City and State or County)
Occupation Farming	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 12 — P. M. on the date above stated.

(Signature) Chas F Zeller M D

(Physician or midwife)

Address Jerome Idaho

Filed 12/27 1930 Chas F Zeller Jerome

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... Birth File No. .....

(If born in hospital or institution
give name)

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the words "stillborn" for name of child)

Sex of child	Twin, triplet or other?	Number in order of birth (To be answered only in case of plural birth)	Legitimate?	Date of birth	
		and		(Month) (Day) (Year)	19

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother including present child ..... Born alive and now living

Born alive but now dead

	FATHER	MOTHER
Full name		
Residence (not place of birth)		
Residence (no place and state)		
Color or race	Age at last birthday (Years)	Age at last birthday (Years)
Birthplace		
Occupation	(City and State or Country)	(City and State or Country)
	(Occupation)	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

Born alive

I hereby certify that I attended the birth of this child, who was stillborn at ..... on the date above stated.

(Signature)

(Physician or midwife)

Address .....

Filed 19

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

187521 +

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73261

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No. ..... Local Registrar's No. 206
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Thompson

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 26/30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	Still Born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jerome Idaho

PARENTS

10. NAME OF FATHER Adam Edgar Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Blanch Perkins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant A. E. Thompson
(Address) Jerome Idaho

15. Filed 12/27, 1930 Chas F. Zeller Jr. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1930, to Dec. 26, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still Born infant
Toxic from mother (Acute Nephritis)
tedious labor
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. F. Zeller M. D.
12/27, 1930 (Address) Jerome, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At Home**, and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer **(retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal **meningitis"**); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms: **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia." "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 7 1931

PLACE OF BIRTH
County of Nez Perce
City of Lewiston
No. ..... St.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

187487

Registration District No. 96 State File No. .....
Reg. Registration District No. 1009 Local Registrar's No. .....

FULL NAME OF CHILD Miscarriage at sixth mo.
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
	(To be answered only in event of plural births)			Yes	Mar. 25 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? X

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn .....

FATHER		MOTHER	
FULL NAME	Lynn Schwandt	FULL MAIDEN NAME	
Residence (Usual place of abode)	Lewiston Ida	Residence (Usual place of abode)	Lewiston Ida
If non-resident, give place and State		If non-resident, give place and State	
Color or race	White Age at last Birthday 23 (Years)	Color or race	White Age at last Birthday 19 (Years)
Birthplace (City and State or County)	Benetton Oregon	Birthplace (City and State or County)	Ruberts Ida
Occupation	Farmer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born Alive~~ / Miscarriage / Stillborn} at ..... A. M. on the date above stated.

(Signature) M. G. Harvey
(Physician or midwife)

Address Lewiston Idaho

Filed 1-2 1931 J. M. Lyle By N. B. Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

639-103-935-863

JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S 187494

CERTIFICATE OF BIRTH

PLACE OF BIRTH

County of Nez Perce

City or Lewiston

No. St. Joseph St.

(If born in hospital or institution give name.)

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD Eugene Frank Flint.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male	—	—	yes	Dec 3 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% Ag NO3

Number of child of this mother, including present birth -1- (a) Born alive and now living 0

Born alive but now dead 0. Stillborn -1-

FATHER		MOTHER	
FULL NAME	Alden Flint.	FULL MAIDEN NAME	Elizabeth Hoelzenovich.
Residence (Usual place of abode)	Culdesac Id.	Residence (Usual place of abode)	Same
If nonresident, give place and State	—	If nonresident, give place and State	—
Color or race	White.	Color or race	White.
Age at last Birthday (Years)	34	Age at last Birthday (Years)	27
Birthplace (City and State or Country)	Osage. Iowa.	Birthplace (City and State or Country)	Lenore. Ida.
Occupation	Mail Carrier	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9:30 P. M. on the date above stated.

(Signature) William S. Hatel M.D.

(Physician or midwife)

Address Lewiston.

Filed Dec 2 1930 J. M. Gyle

(Registrar)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Habel

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73209

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
(No. St. Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECORDED JAN 12 '30
206

2. FULL NAME Baby Flint

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days: Still Born | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Still Born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Ida

PARENTS
10. NAME OF FATHER: Alden Flint
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.
12. MAIDEN NAME OF MOTHER: Elizabeth Holmsworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Alden Flint
(Address): Cardiac Ida

15. Filed, 19. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 1930, to, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Occipital fracture
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Forceps Delivery
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Sign
(Signed) William [illegible] M. D.
12/3/30, 19 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

187491

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

663-112-

PLACE OF BIRTH

RECEIVED JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 187568

County of Shoshone

City of Kellogg

No. ..... St.

Registration District No. 123 File No. .....

Hospital Gardner

Primary Registration District No. 2201 Registered No. 185

FULL NAME OF CHILD None
(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male			Yes	Nov. 12 1930

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1(2)

FATHER	MOTHER
FULL NAME Wallace Glen Woof	FULL MAIDEN NAME Doris Eleanor Tennyson
RESIDENCE Silver King	RESIDENCE Silver King
COLOR White AGE AT LAST BIRTHDAY 40 (Years)	COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Salt Lake City	BIRTHPLACE N. Dakota
OCCUPATION Metallurgist	OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn (Born alive or stillborn) at 9:27 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo H Kennett, MD.
(Physician or midwife)

Address Kellogg, Idaho

Give names added from a supplemental report.

....., 19.....

..... Registrar.

Filed Dec. 28 1930 Mrs. Helen B. Bride Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73394

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 65

206

2. FULL NAME Baby Woolf

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 12, 1930

7. AGE — Years: Stillborn | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg, Idaho

PARENTS

10. NAME OF FATHER W. S. Woolf

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah

12. MAIDEN NAME OF MOTHER Dora Tennyson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mayville, N. Dakota

14. Informant W. S. Woolf
(Address) Kellogg, Idaho

15. Filed Dec. 28, 1930. Mrs. Ellen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased from~~ on Nov 12, 1930, to , 19
that I last saw him ~~alive on~~ dead Nov 12, 1930
and that death occurred, on the date stated ~~above~~, ~~still~~ born m.

The CAUSE OF DEATH* was as follows:
Still born of mother
threatened with eclampsia,
Uterine fibroids (duration) yrs. mos. ds.
Labor being induced spontaneously
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Geo. H. Kennedy, M. D.
Dec 20, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho | Date of Burial: Nov 12, 1930

20. Undertaker: M. C. Thornhill | Address: Kellogg Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" **etc. all diseases resulting from childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 6 1931

PLACE OF BIRTH

County of Teton

City of Victor R.D.

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

187593

Registration District No. 77 State File No.

Prim. Registration District No. 2176 Local Registrar's No. 50

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male | Twin / Triplet / or other? (To be answered only in event of plural births) and Number in order of birth | Legitimate? No | Date of birth 12 (Month) – 14 (Day) – 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead — Stillborn 1

FATHER

FULL NAME Don Ballard

Residence (Usual place of abode) Victor R.D.

If nonresident, give place and State

Color or race White Age at last Birthday 24 (Years)

Birthplace Victor, Ida (City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Ida Callin

Residence (Usual place of abode) Victor R.D.

If nonresident, give place and State

Color or race White Age at last Birthday 26 (Years)

Birthplace Isle Man (City and State or Country)

Occupation Working girl

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 8:30 P. M. on the date above stated.

(Signature) G. Parkinson

(Physician or ~~midwife~~)

Address Driggs, Idaho

Filed 12-30-1930 Martha Marker
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC — JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73133

PLACE OF DEATH
County of Teton
City of Chapin

Registration District No. 77
Primary Registration District No. 2176

Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Estel Barr

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) December 14-30

7. AGE: Years — Months — Days — If LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) Chapin
(State or country) Idaho

PARENTS

10. NAME OF FATHER Don Ballard

11. BIRTHPLACE OF FATHER (city or town) Payson
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Ada Callin

13. BIRTHPLACE OF MOTHER (city or town) Isle Man
(State or Country) ~~Scotland~~

14. Informant Mrs John Michell
(Address) Victor Idaho

15. Filed 12-15-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-14, 1930, to 12-14, 1930
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 8 30 p.m.
The CAUSE OF DEATH* was as follows:
asphyxiation
..... (duration) Sudden yrs. mos. ds.
CONTRIBUTORY (Secondary) Prolapsed umbilical cord
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. Parkinson, M.D.
12-15-, 1930 (Address) Dayton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Darby, Idaho
Date of Burial: 12-16- 1930

20. Undertaker: —
Address: —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. ..... St.

S. T. Cor Ten Hosp

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH RECEIVED JAN 1931

187603

Registration District No. 37 State File No. .....

Prim. Registration District No. 2085 Local Registrar's No. 521

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Male					Dec. 13 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Marion Scott Hafer	FULL MAIDEN NAME	Irene Iverson
Residence (Usual place of abode)	337-3rd West	Residence (Usual place of abode)	Twin Falls
If non-resident, give place and State	Twin Falls	If non-resident, give place and State	
Color or race	W	Color or race	W
Age at last Birthday (Years)	31	Age at last Birthday (Years)	29
Birthplace (City and State or County)	Council Grove Kans.	Birthplace (City and State or County)	Holbrook Ida
Occupation	Carpenter	Occupation	Home Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was [~~Born alive~~ / ~~Stillborn~~] **at** 8 50 **P. M. on the date above stated.**

(Signature) Dr John R Morgan
Twin Falls, Idaho
(Physician ~~or midwife~~)

Address Twin Falls Ida

Filed Jan 5th 1931 Elizabeth J. Smith
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

(File: Registration District No. ..... Local Registrar's No. .....

PLACE OF BIRTH

County of .....

City of .....

No. ..... St. .....

(If born in hospital or institution give name.)

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child	Was Triplet or other? (Total in order of birth)	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)	19....

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

	FATHER	MOTHER
FULL NAME		
COLOR		
Residence (Usual place of abode)		
If non-resident, give place and State		
Color or race	Age at last birthday (Years)	
Birthplace (City and State or Country)		
Occupation		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / stillborn at ..... M. on the date above stated.

(Signature) .....

(Physician or midwife) .....

Address .....

Filed ..... 19....

Registrar.

Where there was no attending physician or midwife, then the father, householder, etc., should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NOTE—In case of more than one child born at one birth, separate records must be made for each child.

NOTE—If a child is born in a hospital or other institution, the name of the hospital or other institution must be given in place of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No. 216

(No. Twin Falls County Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number)

206

2. FULL NAME Baby Hafer

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years X; Months X; Days X; If LESS than 1 day, X hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Twin Falls Ida.

PARENTS

10. NAME OF FATHER Marion S. Hafer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Dren Iverson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant M. S. Hafer.

(Address) 337 3rd ave N. City.

15. Filed 12/27, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 13 (Day) 1930 (Year).

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Still born.

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Endocarditis of Mother
Uterine Tumor
Placenta Lacerantaria.
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John R Morgan, M. D.

....., 19... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls. Date of Burial: 12-15 1930

20. Undertaker: White Mortuary Address: Twin Falls.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. ..... St.

T.T. Co & Gen.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 15 1931

S

CERTIFICATE OF BIRTH

187608

Registration District No. 37 State File No.

Prim. Registration District No. 2085 Local Registrar's No. 516

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin / Triplet / or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)
Male.				yes.	Dec.	10	1930

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 2

FATHER

FULL NAME Frank E. Brown.

Residence (Usual place of abode) Kimberly

If nonresident, give place and State

Color or race W. Age at last Birthday 29 (Years)

Birthplace Beersheba Springs. (City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Mildred Mahnken.

Residence (Usual place of abode) Kimberly

If nonresident, give place and State

Color or race W. Age at last Birthday 21. (Years)

Birthplace Payette Ida. (City and State or Country)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 8:50 P. M. on the date above stated.

(Signature) John H. Coughlin

(Physician or ~~midwife~~)

Address Twin Falls Ida.

Filed Jan 5th 1931. Elizabeth J. Smith Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 14 1931

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73349

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 213

PLACE OF DEATH

County of Twin Falls,
City of Twin Falls,
(No. County Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

No name

206

2. FULL NAME Baby Brown

(a) Residence. No. Kimberly Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): XXXX

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXX

6. DATE OF BIRTH (month, day and year) Dec.-10th-1930

7. AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED XXXXX XX
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls, Idaho.

PARENTS

10. NAME OF FATHER Frank E. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Mildred Mahnken
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Frank E. Brown
(Address) Kimberly, Idaho.

15. Filed 12/27, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 10th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9.30 PM
The CAUSE OF DEATH was as follows:
Still born - due to abdominal complications of pregnancy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John Chambers, M. D.
12-11, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Idaho. Date of Burial: Dec. 11th 1930

20. Undertaker: Grossman Mortuary, Twin Falls, Ida. Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. **If the information cannot be secured, it should be plainly stated unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

BIRTH

County of Ada

City of Boise

No. St.

St Luke's

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 187713

Registration District No. 3 State File No. S

Local Registrar's No. 15

Registration District No. 1004

FULL NAME OF CHILD Stillborn Baby Harris

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate	Date of birth (Month) (Day) (Year)
F				Yes	Dec 16 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 7 (a) Born alive and now living 4

Born alive but now dead 3 Stillborn One

FATHER	MOTHER
FULL NAME O. N. Harris	FULL MAIDEN NAME Mildred Summer
Residence (Usual place of abode) Boise Ida	Residence (Usual place of abode) Boise Ida
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 27 (Years)
Birthplace Cabool Mo (City and State or County)	Birthplace West Point Mo (City and State or County)
Occupation Laborer	Occupation HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 50P M. on the date above stated.

(Signature) W. H. Bosch MD

(Physician or ~~midwife~~)

Address Boise Ida

Filed 1-13 1931 W. N. Chadis Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

47	19
28	2

3	39

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Burial

DO NOT WRITE IN THIS SPACE
State File No. 72941

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1001
Local Registrar's No. 320
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Baby Harris.

(a) Residence. No. 111. Ave. C. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

JAN 12 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 16. 1930.

7. AGE: Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Charles. M. Harris.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Mildred Plummer.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant Charles. M. Harris.
(Address) 111. Ave. C. Boise, Idaho.

15. Filed 12-18 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillborn Dec 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stillborn.

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremia
.....(duration) ....yrs. 1 mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A. B. Bond, M. D.
Dec 18, 1930 (Address) Boise.

19. Place of Burial, Cremation, or Removal: Meridian Mt. | Date of Burial: 12/18 1930

20. Undertaker: Summers & Krebs. | Address: Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At Home**, and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia**; **Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

364-102:009-432

PLACE OF BIRTH

County of Bonner

City of Selmira

No. ..... St.

(If born in hospital or institution give name.)

RECEIVED FEB 9 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 187897

Registration District No. 7F State File No. .....

Primary Registration District No. 2155 Local Registrar's No. 1

FULL NAME OF CHILD Wilson Lodge

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male	✓		✓	yes	Oct. 2nd. 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% Ag NO3

Number of child of this mother, including present birth 5 (a) Born alive and now living 2

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Jas. F Letchus Lodge	FULL MAIDEN NAME Dora McKenzie
Residence (Usual place of abode) Selmira, Idaho.	Residence (Usual place of abode) Selmira, Ida.
If non-resident, give place and State —	If non-resident, give place and State —
Color or race White Age at last Birthday 28 (Years)	Color or race White Age at last Birthday 22 (Years)
Birthplace Bridgewater, Mass. (City and State or County)	Birthplace Selmira, Idaho. (City and State or County)
Occupation Farmer.	Occupation Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 9.50 A. M. on the date above stated.

(Signature) S E Fine

Physician.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Bonners Ferry, Ida.

Filed Feb. 5 1931 Viola Allen

Deputy Registrar.

[illegible]

[illegible]

[illegible]

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72318

PLACE OF DEATH

County of Bonner.

City of Elmira.

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 73

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

304

2. FULL NAME Infant Lodge.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 2, 1930

7. AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

Stillbirth

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Elmira
(State or country) Idaho.

PARENTS

10. NAME OF FATHER James Lodge.

11. BIRTHPLACE OF FATHER (city or town) Budgewater
(State or Country) Mass.

12. MAIDEN NAME OF MOTHER Leona McKenzie

13. BIRTHPLACE OF MOTHER (city or town) Elmira
(State or Country) Idaho.

14. Informant James Lodge.
(Address) Elmira, Idaho.

15. Filed Oct. 2, 1930. Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Eclampsia Separation of the placenta.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Examination.

(Signed) E E Fry, M. D.

Oct. 3, 1930. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: McArthur, Idaho. Date of Burial: Oct. 5 1930.

20. Undertaker: Moon Mortuary. Address: Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18789 n

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED FEB 3 1931

PLACE OF BIRTH

County of Boundary

City of Bonners Ferry

No. ..... St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

187952

Registration District No. 79 State File No.

Prim. Registration District No. 3156 Local Registrar's No.

FULL NAME OF CHILD Baby Frank.
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
male	✓		✓	yes	Dec. 4th 1930.

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Claude Franks	FULL MAIDEN NAME Rose Wolfe
Residence (Usual place of abode) Bonners Ferry Ida	Residence (Usual place of abode) Bonners Ferry Ida
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 38 (Years)	Color or race White Age at last Birthday 34 (Years)
Birthplace Ill. (City and State or County)	Birthplace Germany (City and State or County)
Occupation Laborer	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ / Stillborn } at 9 A. M. on the date above stated.

(Signature) S. E. Fry
Physician
(Physician or midwife)

Address Bonners Ferry, Ida.

Filed Dec. 10-1930. S. E. Fry
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

OCT 1 1950

206

RECEIVED FEB 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73845

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Frank

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 4 - 1930

7. AGE Years | Months | Days | If less than 1 day, hrs. or min.: Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Idaho

PARENTS

10. NAME OF FATHER Claude Frank

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Rose Wolf

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant Claude Frank
(Address) Bonners Ferry Idaho

15. Filed Dec. 4, 1930. E. E. Fry Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 4th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Anencephalus

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E. E. Fry, M. D.
Dec. 4 -, 19 30 (Address) Bonners Ferry Idaho

19. Place of Burial, Cremation, or Removal: Bonners Ferry Ida. | Date of Burial: Dec 6 1930

20. Undertaker: H. P. Crouch, Bonners Ferry | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Latah

City of Deary

No. Home St.

(If born in hospital or institution give name.)

RECEIVED JAN 21

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 188183

Registration District No. 46 State File No. 8

Prim. Registration District No. 2148 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female | Twin Triplet or other? | and | Number in order of birth (To be answered only in event of plural births) | Legitimate? yes | Date of birth Nov. 18 (Month) (Day) 1930 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Harry Enoch Tracy	FULL MAIDEN NAME Hulda Ruth Liner
Residence (Usual place of abode) Deary	Residence (Usual place of abode) Deary
If non-resident, give place and State	If non-resident, give place and State
Color or race White Age at last Birthday 37 (Years)	Color or race White Age at last Birthday 26 (Years)
Birthplace Oregon (City and State or County)	Birthplace Deary, Ida. (City and State or County)
Occupation Woodsman	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 4-10 a. M. on the date above stated.

(Signature) L. W. Porro M. D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Bovill, Ida.

Filed Nov. 21 1930 E. B. Flocker Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

1 [illegible] 3

FILING OF BIRTH

County of .....

City of .....

No. ..... St. .....

Registration District No. ..... State File No. .....

(If born in hospital or institution give name)

Ward, Hospital or Institution ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If multiple, substitute the word "twin" or "triplet" for name of child)

Sex of Child	Twins or triplets?	Number of order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)

(If illegitimate, substitute the word "illegitimate" for name of child)

Was prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of the mother including present child ..... (a) Born alive and now living .....

(b) Born alive but now dead .....

(c) Stillborn .....

FATHER

FULL NAME .....

COLOR OR RACE .....

AGE AT LAST BIRTHDAY .....

BIRTHPLACE (City or Country) .....

OCCUPATION .....

INDUSTRY .....

MOTHER

FULL NAME .....

COLOR OR RACE .....

AGE AT LAST BIRTHDAY .....

BIRTHPLACE (City or Country) .....

OCCUPATION .....

INDUSTRY .....

CERTIFICATE OF ATTENDANT (PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19..

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

FILING OF DEATH

County of .....

City of .....

No. ..... St. .....

Registration District No. ..... State File No. .....

Ward, Hospital or Institution ..... Local Registrar's No. .....

(If in hospital or institution give name)

FULL NAME OF CHILD .....

(If multiple, substitute the word "twin" or "triplet" for name of child)

Sex of Child	Twins or triplets?	Number of order of birth	Legitimate?	Date of birth (Month)	(Day)	(Year)

(If illegitimate, substitute the word "illegitimate" for name of child)

Was prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of the mother including present child ..... (a) Born alive and now living .....

(b) Born alive but now dead .....

(c) Stillborn .....

FATHER

FULL NAME .....

COLOR OR RACE .....

AGE AT LAST BIRTHDAY .....

BIRTHPLACE (City or Country) .....

OCCUPATION .....

INDUSTRY .....

MOTHER

FULL NAME .....

COLOR OR RACE .....

AGE AT LAST BIRTHDAY .....

BIRTHPLACE (City or Country) .....

OCCUPATION .....

INDUSTRY .....

CERTIFICATE OF ATTENDANT (PHYSICIAN OR MIDWIFE)

I hereby certify that I attended the birth of this child, who was born alive on the date above stated.

(Signature) .....

(Physician or midwife)

Address .....

Filed ..... 19..

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

FOR USE OF THE DEPARTMENT OF PUBLIC HEALTH ONLY

In case of death of the child, the death certificate should be made on the reverse side of this form.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED FEB 14 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 188205

PLACE OF BIRTH
County of Lemhi
City of Salmon
No. ..... St.
Dr Hospital
(If born in hospital or institution give name.)

Registration District No. 41 State File No. .....
Prim. Registration District No. 2116 Local Registrar's No. .....

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Male				yes	Dec 8 1930

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of child of this mother, including present birth 1 (a) Born alive and now living .....
Born alive but now dead ..... Stillborn 1

FATHER	MOTHER
FULL NAME Otto J Tigner	FULL MAIDEN NAME Irene Forman
Residence (Usual place of abode)	Residence (Usual place of abode) Salmon
If non-resident, give place and State Salmon	If non-resident, give place and State .....
Color or race wh Age at last Birthday 29 (Years)	Color or race wh Age at last Birthday 21 (Years)
Birthplace Ill (City and State or County)	Birthplace Ref (City and State or County)
Occupation Farmer	Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / Stillborn} at 6P M. on the date above stated.

(Signature) F S Meyer MD
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Salmon

Filed Feb 10 1931 Alice Bellomy
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. ..... State File No. .....

Prim. Registration District No. ..... Local Registrar's No. .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillborn" for name of child)

Sex of (Child): Twin? Triplet? or other? | Number in order of birth (To be answered only in case of twins or triplets) | Legitimate? | Date of birth ..... (Month) (Day) 19.... (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? .....

Number of children, including present birth ..... (a) Born alive and now living .....

Born alive but now dead ..... Stillborn .....

FATHER

FULL NAME .....

Residence (at time of birth) .....

Is non-resident give place and state .....

Color or race ..... Age at last Birthday ..... (Years)

Birthplace ..... (City and State or Country)

Occupation .....

MOTHER

MAIDEN NAME .....

Residence: Usual place of abode .....

Is non-resident give place and state .....

Color or race ..... Age at last Birthday ..... (Years)

Birthplace ..... (City and State or Country)

Occupation .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { born alive / stillborn } at ..... on the date above stated.

(Signature) .....

(Physician or midwife) .....

Address .....

Filed .....

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

PLACE OF BIRTH

County of .....

City of .....

No. ..... St. .....

(If born in hospital or institution give name)

FOLD HERE FIRST—THEN FOLD TO CENTER AND SEAL

NOTE—In case of more than one child or birth of twins or triplets, make one form for each child. Attach all forms together and place in envelope provided.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of PAYETTE.
City of PAYETTE.
No. 1536-1rst.Ave.So.
(If born in hospital or institution give name.)

JAN 17 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

188302

Registration District No. 4 State File No.
Prim. Registration District No. 1008. Local Registrar's No. 73

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	Dec. 29, 1930 19

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME Theodore Edward Newton	FULL MAIDEN NAME Eunice Adele Stringer.
Residence (Usual place of abode) Payette, Idaho	Residence (Usual place of abode) Payette, Idaho
If non-resident, give place and State -----	If non-resident, give place and State ------
Color or race White Age at last Birthday 25 (Years)	Color or race White Age at last Birthday 23. (Years)
Birthplace Oregon (City and State or County)	Birthplace Washington (City and State or County)
Occupation Lumberman	Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } Stillborn at 8.00am. M. on the date above stated.

(Signature) J. C. Woodward M.D.
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payette, Idaho.

Filed Dec 31 1931 J. C. Woodward
Registrar.

206

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED JAN 5 1931

DO NOT WRITE IN THIS SPACE
State File No. 73874

PLACE OF DEATH
County of PAYETTE.
City of PAYETTE.

Registration District No. 4.
Primary Registration District No. 1008.
(No. .....)
Local Registrar's No. 45

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME STILLBORN INFANT OF THEODORE EDWARD NEWTON

(a) Residence. No. DONA DORENE NEWTON. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Stillborn

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6. DATE OF BIRTH (month, day and year) Dec. 29,1930

7. AGE: Years ---------- Months ---------- Days ---------- If LESS than 1 day, ...hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ----------
(b) General nature of industry, business, or establishment in which employed (or employer) ----------
(c) Name of employer ----------

9. BIRTHPLACE (city or town) (State or country) Payette, Idaho.

PARENTS

10. NAME OF FATHER Theodore Edward Newton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon.
12. MAIDEN NAME OF MOTHER Eunice Adele Stringer
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wash.

14. Informant (Address) Theodore Edward Newton Payette, Idaho

15. Filed Dec 29 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 29, 1930. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1930 19 to Dec. 29, 1930 19
that I last saw him alive on ------ 19
and that death occurred, on the date stated above, at 8.00 am m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Stillborn-Dystocia.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) ....., M. D.
12/29/30, 19 (Address) Payette, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Plymouth, Id.	12/29/30 19
20. Undertaker: Theodore Ed. Newton	Address: Payette, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer. Farm laborer, Laborer—Coal Mine** etc. **Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro spinal fever** (the only definite synonym is "Epidmic cerebrospinal meningitis"); **Diptheria** (avoid use of "croup"); **Typhoid Fever** (never report Typhoid pneumonia"); **Lobar Pneumonia; Bronchopneumonia** ("pneumonia," unqualified, is indefite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma,** etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **Septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull and consequences (e.g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of PAYETTE.

City of

No. St.

(If born in hospital or institution give name.)

RECEIVED JAN 17 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 188303

Registration District No. 4. State File No.

Prim. Registration District No. 1008. Local Registrar's No. 72

FULL NAME OF CHILD Stillbirth.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month) (Day) (Year)
Male		Yes.	Dec. 24, 1930. 19

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth 1. (a) Born alive and now living 0)

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME David Sesena.	FULL MAIDEN NAME Welsie Creech.
Residence (Usual place of abode) Payette, Idaho	Residence (Usual place of abode) Payette, Idaho
If non-resident, give place and State --------	If non-resident, give place and State --------
Color or race White Age at last Birthday 21. (Years)	Color or race White Age at last Birthday 18 (Years)
Birthplace Oregon (City and State or County)	Birthplace Montana. (City and State or County)
Occupation Farmer.	Occupation Wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } Stillborn at 3.00am. M. on the date above stated.

(Signature) J. C. Woodward M.D.

Physician.
(Physician or midwife)

Address Payette, Idaho.

Filed Dec 31 1931 J. C. Woodward
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

5

1 F 5303

Place of birth: Fayette, Idaho

Sex: Male

Date of birth: Dec. 1, 1930

Name of child: None

Father's name: David Essena

Father's birthplace: Oregon

Father's race: White

Father's age: 19

Mother's name: Velate Essena

Mother's birthplace: Montana

Mother's race: White

Mother's age: 19

Number of children of this mother including this child: 1

Number of children of this mother living: 1

Number of children of this mother including this child, now living: 1

Number of children of this mother including this child, now living and born in this county: 1

Was prophylactic eye treatment given? None

Date of this certificate: Dec. 1, 1930

Signature of attending physician or other person: Pr. Blain

Address: Fayette, Idaho

I hereby certify that I attended the birth of this child, who was born on the date above stated.

Signature of attendant: Pr. Blain

Address: Fayette, Idaho

Date: Dec. 1, 1930

Where there was no attending physician or midwife, then the father, householder, etc., should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

CERTIFICATE OF ATTENDANCE ON STILLBIRTH

Date of stillbirth: _____

Signature of attendant: _____

Address: _____

Date: _____

188303

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 1 1931

Oregon State Board of Health — Certificate of Death

74198

State Registered No. .....

1. PLACE OF DEATH County Multnomah State Ore. Local Registered No. 48

Township ..... or Village ..... or

City Payette No. ....., ... St., ... Ward

(If death occurred in a hospital or institution, give its name instead of street number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Baby of D. R. Lesesne

(a) Residence: No. Payette St. 706

(Usual place of abode) (If nonresident, give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: White

5. Single, Married, Widowed or divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Dec 24, 1930

7. AGE: Years | Months | Days: Stillborn (no age) | If less than 1 day, ... hrs. or .... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, sawmill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Payette Idaho

FATHER

13. NAME D. R. Lesesne

14. BIRTHPLACE (city or town) (State or country) Oregon

MOTHER

15. MAIDEN NAME French

16. BIRTHPLACE (city or town) (State or country) Vermont

17. INFORMANT D. R. Lesesne

(Address) Payette, Idaho

18. BURIAL, CREMATION OR REMOVAL

Place Mountain View Date Dec 26, 1930

19. UNDERTAKER H. L. Dillmann

(Address) Ontario, Ore.

20. Filed Dec 31, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Dec 24 1930

22. I HEREBY CERTIFY, That I attended deceased from 12/24/30 to 12/24/30, 19..., that I last saw him alive on 12/24/30, 19..., death is said to have occurred on the date stated above, at 8:00 m.

The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
Dystocia	
Prolonged Labor	

Contributory causes of importance not related to principal cause:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and state)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) J. C. Woodward M. D.

(Address) Payette, Ida.

OCT 14 1975

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed on account of the disease causing death, report the occupation prior to illness. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housework* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *housekeeper—private family, cook—hotel,* etc. For a person who had no occupation whatever write *none.*

To be complete, an occupation return must state:

8. The trade, profession, or particular kind of work done.
9. The industry or business in which the work was done.
10. The month and year the deceased last worked at the occupation.
11. The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employe," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver,* etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill,* etc.

Distinguish carefully the different kind of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer,* etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter, painter, machinist,* etc. Distinguish carefully between *retail merchants* and *wholesale merchants.* A person who sells goods should be called a *salesman* and not a *clerk.*

Statement of cause of death—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.,* heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under contributory causes of importance not related to principal cause, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance in order of onset were as follows:	**Date of onset**
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Contributory causes of importance not related to principal cause:	
Fracture of arm	
Automobile accident	*May 3, 1927*

Example II

The **principal cause of death** and related causes of importance in order of onset were as follows:	**Date of onset**
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Contributory causes of importance not related to principal cause:	
Influenza	*6 weeks ago*

In a group of causes containing the principal cause and related causes, the causes should be given in the order of onset, so that in a group of three causes the principal cause may appear in either first, second, or third position. The principal cause in each of the above examples happens to be the second cause given.

Additional Space for Further Statements by Physician

.....

.....

.....

993-238-038-693

PLACE OF BIRTH

County of Payette

City of Payette

No. ..... St.

(If born in hospital or institution give name.)

RECEIVED JAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

188305

Registration District No. 4 State File No. .....

Prim. Registration District No. 1008 Local Registrar's No. 70

FULL NAME OF CHILD ..... (If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female				Yes	Dec. 30 1930

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 7 (a) Born alive and now living 2

Born alive but now dead ..... Stillborn 5

FATHER	MOTHER
FULL NAME Guy Cutsinger	FULL MAIDEN NAME Mabel Orcutt
Residence (Usual place of abode) Payette, Idaho	Residence (Usual place of abode) Payette, Idaho
If non-resident, give place and State	If non-resident, give place and State .....
Color or race White Age at last Birthday 37 (Years)	Color or race White Age at last Birthday 38 (Years)
Birthplace Payette, Idaho (City and State or County)	Birthplace Minnesota (City and State or County)
Occupation Farmer	Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 5 P M. on the date above stated.

(Signature) T. A. Benjamin M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payette, Idaho

Filed Dec 31 1930 J. C. Woodward Registrar.

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF OHIO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

(CERTIFICATE OF BIRTH)

Registrarian's District No. ..... State File No. 1943-03

Registration District No. ..... Local Registrar's No. .....

(If born in hospital, institution or other place)

No. ..... St. .....

City or village .....

County of birth .....

FULL NAME OF CHILD .....

(If stillborn, substitute the word "stillborn" for name of child)

Sex of child ..... Twin, triplet, or other ..... Number in order of birth ..... Legitimate? ..... Date of birth ..... 19..... (Month) (Day) (Year)

Was prophylactic used to prevent Ophthalmia Neonatorum? .....

Number of child of this or other multiple birth ..... (a) Born alive and now living .....

Born alive but now dead .....

Stillborn .....

	FULL NAME (PLEASE PRINT)	NOTHING
Father		
Mother		

Residence of father .....

Residence of mother .....

Birthplace of father .....

Birthplace of mother .....

Maiden name of mother .....

Color or race ..... Age at last birthday ..... Age at last birthday .....

Birthplace ..... (City and State or County) ..... (City and State or County)

Occupation ..... (Occupation) .....

CERTIFICATE OF ATTENDANT OR PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive / stillborn on the date above stated.

(Signature) .....

Address ..... Physician or midwife

Filed ..... 19.....

Registrar

If born there was no attending physician or midwife, then the father, householder, or other person, state the facts. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

7. R.—In case of twins and triplets, one copy and the duplicate of each should be sent to Bureau of Vital Statistics, Ohio Department of Public Welfare.

512-115 040-792

PLACE OF BIRTH

County of Shoshone

City of Kellogg

No. St.

Kellogg Maternity Home

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

188966

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No. 8

FULL NAME OF CHILD Stillborn — Vasiloff

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
Boy				yes	Sept. 15 1930 (Month) (Day) (Year)

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol 10%

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	Peter Vasiloff	FULL MAIDEN NAME	Mary Gibson
Residence (Usual place of abode)	Wardner	Residence (Usual place of abode)	Wardner
If non-resident, give place and State		If non-resident, give place and State	
Color or race	Turk	Color or race	White
Age at last Birthday (Years)	31	Age at last Birthday (Years)	30
Birthplace (City and State or County)	Turkey	Birthplace (City and State or County)	Idaho
Occupation	Laborer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {~~Born alive~~ / Stillborn} at 4:30 A. M. on the date above stated.

(Signature) W. C. Lindsay

Physician

(Physician or midwife)

Address Kellogg Idaho

Filed Feb. 27 1931 Miss Helen M. Beale

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72169

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

204

2. FULL NAME Baby Vasiloff

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept. 15, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, Still hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kellogg Idaho

PARENTS

10. NAME OF FATHER: Peter Vasiloff
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Constantinople
12. MAIDEN NAME OF MOTHER: Mary Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hood River Oregon

14. Informant: Peter Vasiloff
(Address): Kellogg Idaho

15. Filed Sept. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept, 1930 that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Breech Delivery
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kellogg Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. L. Lindsay, M. D.
9/16, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida — Date of Burial: Sept 16 1930

20. Undertaker: P. L. Stout — Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

188966 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 813211

County of Bannock 003557

City of Pocatello

No. St Anth cny St. Hosp

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAR 6 1931

CERTIFICATE OF BIRTH

189124

Registration District No. 28 State File No.

Prim. Registration District No. 261 Local Registrar's No. 10155

FULL NAME OF CHILD Stillborn Hatch
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
Female			Yes	12/11/30/ 19

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo-Silvol

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Simmons F Hatch	FULL MAIDEN NAME Tressa England
Residence (Usual place of abode) Robin Idaho	Residence (Usual place of abode) Robin Idaho
If non-resident, give place and State " "	If non-resident, give place and State " "
Color or race W Age at last Birthday 40 (Years)	Color or race W Age at last Birthday 40 (Years)
Birthplace Franklin Utah (City and State or County)	Birthplace Plain City Utah (City and State or County)
Occupation Farmer	Occupation H.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 1.45 A. M. on the date above stated.

(Signature) J. K. Call

(Physician ~~or midwife~~)

Address Pocatello Ida

Filed 3-1 1931 D. Kay
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72988

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. Bannock 28
Primary Registration District No. 2161 Local Registrar's No. 5957
(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931
206

2. FULL NAME Infant Hatch

(a) Residence. No. Moreland Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 11, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	0 hrs. or 0 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER S.F. Hatch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Tressa England

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant S,F. Hatch
(Address)

15. Filed 12/12/30, 19 J. H. Gormy. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December, 11, 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Last lived in 1930, 19 to 1930, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
The mother was sick
type swinging for
about 10 days, w/ delivery
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) /
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [illegible], M. D.
12/12, 1930 (Address) Pocatello Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Moreland Idaho	12/12/30 19
20. Undertaker	Address
Arthur W. Hall	Poca. Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., **Farmer, Physician, Stenographer,** Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Saleman,** (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as **Day laborer Farm laborer. Laborer—Coal Mine etc. Women at** home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At Home,** and children not gainfully employed, as **At school** or **At Home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

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PERSONAL FIGURES

County of Cassia

City or Burley

No. 723 So. 3rd St.

Hosp. 113 003 851

RECEIVED JUN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

201956

Registration District No. 28

(If born in hospital or institution give name.)

Prim. Registration District No. 261 Local Registrar's No. 193

201956

FULL NAME OF CHILD Still birth Maurer

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth (Month) (Day) (Year)
boy	—		—	Yes	Dec. 13 19

(To be answered only in event of plural births)

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% Argyrol

Number of child of this mother, including present birth 1 (a) Born alive and now living none

Born alive but now dead none Stillborn none

FATHER		MOTHER	
FULL NAME	B. F. Maurer	FULL MAIDEN NAME	Helen Marion Heaps
Residence (Usual place of abode)	Powell Idaho	Residence (Usual place of abode)	Powell Id
If non-resident, give place and State		If non-resident, give place and State	
Color or race	white Age at last Birthday 25 (Years)	Color or race	white Age at last Birthday 2 (Years)
Birthplace	Oklahoma (City and State or County)	Birthplace	Salt Lake Cty Utah (City and State or County)
Occupation	Laborer	Occupation	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive / ~~Stillborn~~} at 6 P. on the date above stated.

(Signature) W. W. Brothers

(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Powell Idaho

Filed 5-31 1932 D C Ray

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN for each and the number of each, in order of birth stat

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72987

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5958

2. FULL NAME Infant Maury.
(a) Residence. No. 723 - No. 3 Ld. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

206

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): none.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 13-1930

7. AGE: Years | Months | Days | If LESS than 1 day, 8 hrs. or None min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS
10. NAME OF FATHER O. L. Maury.
11. BIRTHPLACE OF FATHER (city or town) Okla.
(State or Country)
12. MAIDEN NAME OF MOTHER Helen Heaps
13. BIRTHPLACE OF MOTHER (city or town) Utah.
(State or County)

14. Informant Mr. O. L. Maury.
(Address)

15. Filed 12/15, 1930 J. H. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 13, 1930
that I last saw him alive on Dec 13, 1930
and that death occurred, on the date stated above, at 2:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) W. Brother, M. D.
12-14, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal: Mt. View Cemetery — Date of Burial: 12-14 1930
20. Undertaker: H. L. McBan — Address: Poca. Idaho

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